STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146117	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casey Rehab and Nursing	100 N.E. 15th Casey, IL 62420

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide adequate pain control for one (R2) of three residents reviewed for pain on the sample list of seven.Findings Include: R2's Physician Order Sheet (POS) dated August 2025 documents R2 was admitted to the facility on [DATE]. R2 is diagnosed with Type II Diabetes Mellitus with Diabetic Polyneuropathy and Muscle Weakness among other medical diagnoses. R2's POS documents a physician order on 7/4/25 for Acetaminophen tablets 650 milligrams by mouth every six hours as needed for mild pain. If more than three doses given in 48 hours- staff are to notify the physician or advanced practice provider. R2's POS documents a physician order on 7/14/25 for Tramadol 50 milligrams by mouth as needed for pain. R2's Medication Administration Record (MAR) dated July 2025 documents R2 received more than three doses of Acetaminophen in 48 hours' time on 7/7/25, 7/8/25, 7/9/25, 7/10/25, 7/11/25, and 7/12/25. There is no documentation that a physician or advanced practice provider were notified of R2's frequent use of the as needed Acetaminophen. The MAR documents R2 rated her pain at an eight or higher for eleven of the fourteen Acetaminophen doses administered from 7/7/25 to 7/12/25. R2's Progress Note dated 7/11/25 at 8:40 PM documents R2 complained of right shoulder pain and V2 Director of Nurses requested a more effective pain medication and was waiting on response from the advance practice nurse. R2's Progress Note dated 7/12/25 at 2:57 AM documents V15 Medical Director was notified of R2's increased pain and request for better pain control. V15 ordered Tramadol 50 milligrams every eight hours as needed for pain. However, V15 could not send the new script to the pharmacy because V15 was not in his office. On 8/13/25 at 3:05 PM V2 Director of Nurses confirmed R2 often complained of pain during her stay in the facility. V2 confirmed R2 was given Acetaminophen more than three times in 48 hours on multiple occasions throughout her stay. V2 confirmed nursing should have notified a physician concerning the continued use of acetaminophen per the order. V2 confirmed on the evening of 7/11/25 R2's pain was unbearable for her, and she requested a stronger pain medication than Acetaminophen. R2 stated she reached out the to the Nurse Practitioner on-call however did not hear back so the nurse on duty overnight (V9 Registered Nurse) reached out to V15 Medical Director (MD) for a different pain medication order. V2 stated V15 ordered Tramadol however could not send the new script to the pharmacy so the nurses could not get the medication out of the medication dispensing machine. V2 confirmed R2 was not able to receive the new Tramadol medication until 7/12/25 at 3:16 PM. V2 stated R2 was tearful and uncomfortable throughout the night. V2 stated staff repositioned her and tried to keep her as comfortable as possible but there was a delay in getting her the pain medication that should not have happened. V2 stated R2's pain did improve some with the administration of the Acetaminophen however she did still require an increase in pain relief (Tramadol) and should not have had to wait 18 hours for the medication to be available. V2 acknowledged a change in procedure is required to make sure medications are available when needed for residents even after hours or on weekends.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate services for a resident with a diagnosis of dementia for one resident (R7) of three residents reviewed for dementia services on a sample list of seven.Findings include: R7's Physician Orders Sheet (POS) dated August 2025, documents R7's diagnosis as: Dementia, mild, with agitation and anxiety disorder.R7's Wandering/Elopement Risk assessment dated [DATE], documents R7 is high risk for elopement.On 8/13/25 at approximately 10:30 AM, a personal alarm was sounding. V7 Certified Nursing Assistant (CNA) ran out the front door towards R7 who was seen walking towards the parking lot. V7 CNA assisted R7 back into the building to the Business Office with V12 Business Office Manager (BOM). On 8/13/25 at approximately 12:10 PM, a personal alarm was sounding. V2 Director of Nursing (DON) ran out the front door towards R7 who was seen walking towards the parking lot. V2 DON assisted R7 back into the building. On 8/13/25 at 12:14 PM, V2 DON stated R7 is very agitated today. V2 stated R7 worries about going to the bank, worried about R7's jeweler, and paying R7's bills. V2 stated R7 is progressively declining. V2 stated staff should be doing 15-minute checks on R7 and making sure R7's needs are being met. V2 stated V12 BOM has not had dementia training and may not know what to do with/for R7. V2 stated dementia training should be completed immediately after starting (working). On 8/13/25 at 12:57 PM, V1 Administrator stated R7 was put on 1:1 with staff after the last time R7 tried to escape. V1 stated just in the last two to three days R7 has been going to the door. V1 stated R7 does have an alarm bracelet on, R7 was given a calendar to show when rent is due, and staff has been letting R7 go out into the courtyard. V1 stated dementia training should be done with onboarding and before starting work at the facility. On 8/13/25 at 1:18 PM, V7 CNA stated V7 took R7 to the business office because R7 always wonders about paying R7's rent. V7 stated R7 does exit seek because R7 is always wants to go to the bank and wondering about rent. On 8/13/25 at 1:45 PM, V2 DON stated R7 was exit seeking a few weeks ago but it has been more frequent this week, so we are moving R7 to the south hall (locked unit). V2 also stated the nurses should be documenting the follow up from R7 getting out of the facility and what interventions were used.R7's Nursing Progress Notes written by V5 LPN, dated 8/8/25 at 1:26 PM, documents exit seeking x 2, continues to think he needs to go to the bank to make arrangements to pay the rent, re-education unsuccessful due to cognition. R7's Nursing Progress Notes written by V5 LPN, dated 8/11/25 at 1:46 PM, documents exit seeking x 3 out the front door, staff had to assist back inside.On 8/13/25 at 1:52 PM, V5 Licensed Practical Nurse (LPN) stated V5 continued to remind R7 his bank account is not here, and someone takes care of R7's business. V5 stated the only other options we have are to follow R7 around or walk with R7 and keep trying to explain this to him to help R7 remember, keep repeating things to him. V5 stated this man (R7) goes out the door about every day and it has been going on for the last week and a half on a daily basis. On 8/13/25 at 2:55 PM, V6 Registered Nurse (RN) stated she does not know where the elopement logbook is and can't say V6 was ever showed that.On 8/13/25 at 3:00 PM, V14 RN, stated V14 is still kind of new so V14 is not sure where the elopement logbook is.The facility's Wandering and Elopement Assessment and Prevention Policy dated Revised 6/4/24, documents all residents shall be assessed for risk of elopement/unsafe wandering, to ensure their safety and prevention from elopement. This same policy documents all departments shall be made aware of the elopement log and the location. This policy also documents the facility uses a multi-faceted approach to prevent elopement including staff education regarding understanding wandering, responsibility to identify, report, and intervene for wandering/elopement risk for residents.