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	01/08/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, facility staff (V3 and V5, Certified Nursing Assistants, and V6 Registered Nurse) failed to report allegations of observed and known potential abuse in the required immediate, not more than 24 hour, time frame. This failure has the potential to affect three residents (R2, R3, and R4) out of twelve reviewed for abuse on the sample list of thirteen.Findings include:1. The facility Investigation Report with an initial date of 11/10/25 documents an allegation of V4, Certified Nursing Assistant, hitting R2 with a positioning cushion and stating, I hate you, which was allegedly witnessed by V3, Certified Nursing Assistant. This report documented an investigation detail that the alleged event occurred on 10/27/25. R2 was not interviewable due to severe cognitive impairments. On 1/6/26 at 2:16 PM, V4 stated the alleged incident did not happen. V4 denied having any personal problems with V3. On 1/6/26 at 3:40 PM, V1, Administrator, stated this alleged incident occurred on 10/27/25 according to the staff schedules when V3 and V4 had worked together. V1 confirmed V3 was a new employee at that time and had participated in the new employee training about abuse reporting prior to working any shifts at the facility. On 1/8/26 at 9:55 AM, V3 stated she had witnessed the incident as alleged on 10/27/25 but had not reported the incident until about a week later. V3 stated she was concerned being a new employee and didn't want to experience any backlash from other employees for reporting. V3 denied having any personal problems with V4. On 1/8/26 at 12:49 PM, V2, Director of Nursing, stated V3 did report the allegation to herself in the presence of V13, Business Office Manager, on 11/10/25. V2 confirmed the staffing schedules determined the alleged incident had to have occurred on 10/27/25. V2 stated there had been a previous situation between V3 and V4 when each of the employees felt like the other one was not helping during provisions of resident care and V2 had to implement a verbal intervention about working together as a team. V3's Training Acknowledgement Form dated and signed by V3 on 10/17/25 documents it is the team member responsibility to report immediately to your supervisor any signs of abuse or neglect. This form further documents alleged violations involving mistreatment, neglect or abuse, including injuries of unknown origin, and misappropriation of resident property are to be reported to the facility administrator. This form further documents the employee must report any occurrences of mistreatment observed, heard about, or suspected, no matter what the situation or perpetrator, immediately. 2. The facility Investigation Report with an initial date of 12/1/25 documents an allegation of a resident to resident verbal altercation occurred on 11/29/25 between R3 and R4 wherein R3 threatened to beat R4. On 1/7/26 at 11:25 AM, R3 and R4 stated they get along fine, but confirmed each other that they had arguments in the past because both of them are straight honest and tell it like it is. On 1/6/26 at 3:40 PM, V1, Administrator, stated there had been two staff witnesses to the altercation between R3 and R4, but neither of them had reported the incident to V1. V1 stated the two staff members were V5, Certified Nursing Assistant, and V6, Registered Nurse, a former employee. V1 stated she had learned of the incident because V6 had made a progress note in the electronic medical record (continued on next page)

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

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	system which was dated 11/29/25 (Saturday). V1 stated she learned of the altercation on Monday morning 12/1/25 when she read the reports in the electronic medical record system. V1 confirmed neither of the witnessing employees had called her to report the altercation and she had spoken to V5 during the investigation. On 1/8/26 at 10:25 AM, V5 stated she had witnessed a verbal altercation between R3 and R4 when R3 threatened to beat R4 and had separated the two residents. V5 stated she reported the altercation to the nurse on duty (V6), albeit the facility investigation report documented V5 stated she had not reported it because V6 was present during the altercation. V5 stated she had not reported the altercation to the administrator but did talk to the administrator on 12/2/25 and then stated 12/2/25 was the same date as the altercation. On 1/8/26 at 12:49 PM, V2, Director of Nursing, stated she had been the on-call manager for the weekend of 11/29 and 11/30/25, and neither V5 nor V6 had called her to report the altercation between R3 and R4. V2 stated she had learned of the altercation on Monday morning 12/1/25 at the same time as V1 by reading the reports in the electronic medical record system. V2 stated V6 had signed a statement documenting V6 had received the abuse prevention training about reporting according to facility policy. V6 was not available for an interview. V5's Training Acknowledgement Form dated and signed by V5 on 9/5/25 documents it is the team member responsibility to report immediately to your supervisor any signs of abuse or neglect. This form further documents alleged violations involving mistreatment, neglect or abuse, including injuries of unknown origin, and misappropriation of resident property are to be reported to the facility administrator. This form further documents the employee must report any occurrences of mistreatment observed, heard about, or suspected, no matter what the situation or perpetrator, immediately. The facility abuse prevention policy dated 10/16/23 documents the facility will ensure all associates are properly trained according to the training policies and will ensure all allegations or suspicions of abuse will be reported in the proper timeframe.