

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Casey Rehab and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Failures at this level required more than one deficient practice statement.A. Based on observation, interview and record review the facility failed to supervise a resident during a shower for one of three residents (R1) reviewed for falls in the sample of three residents. This failure resulted in R1 falling from the wheelchair during a shower when staff turned away from R1 and R1 suffering from a left pelvic fracture. This past noncompliance occurred from 5/29/26-6/1/26.B. Based on interview and record review the facility failed to supervise a resident during meal time for one of three residents (R2) reviewed for falls on the sample list of three residents. This failure resulted in R2 falling when R2 was left unsupervised in the dining room and suffering a left posterior scalp laceration requiring three staples. This past noncompliance occurred from 6/5/26-6/6/26.Failures at this level required more than one deficient practice statement.A. Based on observation, interview and record review the facility failed to supervise a resident during a shower for one of three residents (R1) reviewed for falls in the sample of three residents. This failure resulted in R1 falling from the wheelchair during a shower when staff turned away from R1 and R1 suffering from a left pelvic fracture. This past noncompliance occurred from 5/29/26-6/1/26. B. Based on interview and record review the facility failed to supervise a resident during meal time for one of three residents (R2) reviewed for falls on the sample list of three residents. This failure resulted in R2 falling when R2 was left unsupervised in the dining room and suffering a left posterior scalp laceration requiring three staples. This past noncompliance occurred from 6/5/26-6/6/26.Findings include: A. R1's Electronic Medical Record (EMR) documents medical diagnoses as Acute Left Pelvic fracture, Osteoarthritis of Knee, Presence of artificial eye, Disorders of bone density and structure, Alzheimer's Disease, History of Lumbosacral Spine and Pelvic fracture, Dementia and Malaise.R1's Fall Risk assessment dated [DATE] documents R1 as a moderate fall risk.R1's Minimum Data Set (MDS) dated [DATE] documents R1 as severely cognitively impaired. This same MDS documents R1 is dependent on staff for total assistance with eating, oral hygiene, toileting, bathing, dressing, personal hygiene, bed mobility and transfers.R1's fall care plan intervention dated 4/21/26 documents R1 does not understand mobility limits due to cognitive limitations. This same intervention documents R1 will try to get up from bed/chair unassisted.R1's Nurse Progress Note dated 5/29/26 at 3:41 PM documents R1 slid out of the shower chair with V4 CNA (Certified Nurse Aide) present. This same note documents, (R1) was soapy and slipped out of the chair onto her left side on the floor, bumped forehead and left wrist on the wall. R1's fall investigation dated 5/29/26 documents R1 slid out of a facility shower chair with V4 Certified Nurse Aide (CNA) present. This same report documents R1 was soapy and slipped out of the shower chair. This same report documents the root cause for R1's fall was due to R1was leaning forward and slid out of the shower chair. R1's Final report to the State Agency date 6/4/26 (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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F 0689 Level of Harm - Actual harm Residents Affected - Few	documents R1 sustained a fall in the facility which resulted in R1's left pelvic fracture. On 7/21/26 at 11:00 AM the facility reclining shower chair was being used by staff for another resident. On 7/21/26 at 11:05 AM V4 Certified Nurse Aide (CNA) stated V4 transferred R1 by herself from her wheelchair to a facility shower chair on 5/29/26. V4 stated V4 had R1 very soapy when V4 turned her back to get a washcloth to cover R1's eyes before rinsing the soap off R1. V4 CNA stated that is when R1 leaned forward and fell out of her shower chair. V4 CNA stated R1 landed on her left side on the shower room floor, still in the shower stall. V4 CNA stated R1 leans forward in her wheelchair frequently. V4 CNA stated R1 should have been placed in the facility reclining shower chair but did not realize the facility had a shower chair that reclined. V4 CNA stated she should not have turned her back on R1 knowing that R1 was very soapy and leans forward on her own frequently. V4 CNA stated R1 has Alzheimer's Disease and cannot make safety decisions on her own. On 7/21/26 at 12:30 PM V3 Assistant Director of Nurses (ADON)/Licensed Practical Nurse (LPN)/fall nurse stated V3 was the first nurse to assess R1 after falling on 5/29/26. V3 LPN stated R1 was lying on her left side on the shower room floor still in the shower stall. V3 LPN stated V4 CNA was showering R1 when V4 CNA applied soap, then turned her back on R1 and R1 fell out of her shower chair. On 7/21/26 at 2:45 PM V1 Administrator stated V4 CNA should not have turned her back on R1 when showering R1. V1 Administrator stated the staff are encouraged to use all the tools needed to ensure every resident is safe. V1 stated V4 CNA should have used better judgement when caring for a severely cognitively impaired resident. V1 Administrator stated the staff have been in serviced on resident safety and the facility fall policy. V1 Administrator confirmed the facility caused R1's Left Pelvic fracture by placing R1 at risk for falling when V4 CNA turned around not monitoring R1. Prior to the date of the survey, the facility took the following actions to correct the noncompliance.Effective June 1, 2026, [NAME] Rehab and Nursing implemented the following corrective measures:1. A new fall intervention was implemented on 6/1/26, requiring use of a tilted shower chair during the resident's shower.2. Staff education was completed on 6/1/26, regarding the facility's Fall Reduction Policy and the newly implemented intervention requiring use of the tilted shower chair.3. Audits were initiated on 6/1/26, to monitor compliance with the use of the tilt shower chair.4. The facility incorporated the identified root cause and corrective intervention into its ongoing fall prevention and monitoring processes.5. A quality improvement action plan was initiated on 6/1/26 and the fall will be discussed in the next scheduled QAPI meeting on 7/28/26.B. R2's Electronic Medical Record (EMR) documents medical diagnoses as Acute Left Posterior Scalp Laceration, Vascular Dementia, Atrial Fibrillation, Neurocognitive Disorder, Vitamin B12 Deficiency, Psychotic Disorder with Delusions, Anxiety, Gastro-Esophageal Reflux Disease (GERD), Encephalopathy and Dementia.R2's Fall Risk assessment dated [DATE] documents R2 as a fall risk.R2's Minimum Data Set (MDS) dated [DATE] documents R2 as severely cognitively impaired. R2 as being dependent on staff for oral hygiene, dressing, toileting, bathing, personal hygiene, bed mobility and transfers.R2's Fall Care Plan intervention dated 6/17/25 instructs staff to anticipate R2's needs. A fall intervention dated 11/4/25 for R2 to eat with only supervision. The Care Plan documents a fall intervention dated 12/8/25 for staff to be educated on resident supervision needs while up in wheelchair. An intervention dated 4/4/25 for staff to toilet R2 every hour. R2's Nurse Progress Note dated 6/5/26 at 6:04 PM documents R2 had an unwitnessed fall in the dining room. R1 obtained a laceration to the back of her scalp and was sent to the emergency room.R2's Nurse Progress Note dated 6/8/26 at 8:47 AM documents the facility Interdisciplinary Team (IDT) reviewed R2's fall from 6/5/26. The root cause of R2's fall was determined to be R2 standing out of wheelchair without assistance.R2's Hospital Record dated 6/5/26 documents R2 presented to the emergency room after having an unwitnessed fall at the facility. R2 obtained a one centimeter (cm) (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	scalp laceration and staples could have been prevented if staff were monitoring R2. V2 DON stated R2 is known for pushing herself back from the dining room table and is known for rocking back and forth in her wheelchair. V2 DON stated R2 was known for standing up unattended prior to R2's fall on 6/5/26. On 7/22/26 at 12:05 PM V1 Administrator stated the facility does not have a policy on monitoring the dining room due to this is a common area. V1 stated residents should be monitored during mealtime. The facility policy titled Fall Reduction Policy revised January 4, 2026 documents the facility will provide an environment that remains as free of accident hazards as possible. The facility will provide supervision and assistive devices to prevent or minimize fall related injuries. Prior to the date of the survey, the facility took the following actions to correct the noncompliance. 1. On 6/6/26 a pommel cushion was placed in R2's wheelchair to ensure proper positioning. 2. R2's Care Plan was updated on 6/6/2026 to include R2's new pommel cushion for positioning. 3. On 6/6/2026 staff were in-serviced on the use/placement of R2's pommel cushion. 4. On 6/6/2026 an audit was initiated to ensure R2's pommel cushion was being utilized by staff. This audit is ongoing. 5. On 6/8/26 the Quality Assurance team discussed R2's fall on 6/8/26 during the weekday Quality Assurance meeting. The next quarterly Quality Assurance Performance Improvement (QAPI) meeting is scheduled for 7/28/26. V1 Administrator stated both R1 and R2's falls will be discussed in the quarterly QAPI meeting on 7/28/26. These meetings are ongoing.		