STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010227	A. BUILDING: _____ B. WING _____	04/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASEYVILLE NURSING & REHAB CTR	601 WEST LINCOLN AVENUE CASEYVILLE, IL 62232

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Annual Licensure Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3)6) 300.3240a)	S9999		

Section 300.610 Resident Care Policies

a)The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Attachment A
Statement of Licensure Violations

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010227	A. BUILDING _____ B. WING _____	04/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASEYVILLE NURSING & REHAB CTR	601 WEST LINCOLN AVENUE CASEYVILLE, IL 62232

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 1	S9999		

and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.
6)All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met evidencded by:

a. Based on observation, record review, and interview, the facility failed to assess residents for root cause of falls, provide increased supervision, implement progressive intervention and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010227	A. BUILDING _____ B. WING _____	04/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASEYVILLE NURSING & REHAB CTR	601 WEST LINCOLN AVENUE CASEYVILLE, IL 62232

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 2	S9999		

review/revise these interventions as needed to prevent falls for 3 of 14 residents (R91, R47 and R84) reviewed for falls in the sample of 54. This failure resulted in R91 receiving a right hip fracture, and R47 receiving a fracture of the left femur.

Findings include:

1. R91's Minimum Data Set (MDS), dated 11/5/18, documents a Brief Interview for Mental Status score (BIMS) score of 11 indicating R91's cognition is moderately impaired. R91's MDS further documents R91 requires extensive assist with two or more persons for toilet use and is not steady moving on and off the toilet and is only able to stabilize with staff assistance. R91's MDS dated 3/28/19 documents a BIMS score of 15 indicating R91 has intact cognition.

On 04/16/19 at 9:30 AM R91 stated "Can you take me to the bathroom?" Both Certified Nurse Assistants (CNA's) were helping others, R91 was informed. At 9:40 AM R91 continued to state she had to go to the bathroom. R91 stated "Well I better get up and take myself." The nurse was notified that R91 stated she would take herself to the bathroom. The nurse took her to the bathroom at this time.
R91's Fall Investigation Report, dated 11/19/18 at 2:55 PM documents "Another nurse reported to this nurse that resident was found lying on her back on D-hall bathroom floor. Assessment complete, Range of Motion (ROM) performed, no apparent injuries at this time. Immediate action taken: Neurological checks with in normal limits."

There was no documentation in R91's medical record that the facility had conducted any type of assessment to determine the root cause of this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010227	A. BUILDING: _____ B. WING _____	04/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASEYVILLE NURSING & REHAB CTR	601 WEST LINCOLN AVENUE CASEYVILLE, IL 62232

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3	S9999		

fall.

R91's Risk Management Note, effective date 11/20/19, documented "Resident is mobile ad lib via w/c. Does require 1 assist for transfers. On restorative programs for ambulation and AROM (Active Range of Motion). On skilled therapies. Ambulates with W/W (wheeled walker) and assist. S/P (Status Post) fx (fracture) Rt (right) femur. Will continue to educate resident on safety and assist her with mobility as needed. Isolated occurrence."

R91's Fall Investigation Report, dated 12/4/18 at 2:30 PM, documents "Called to E -hall bathroom by staff, noted resident sitting on floor in front of her wheel chair (w/c). Moves all extremities without difficulty. No rotation to hips noted. Wheel chair brakes engaged, not working properly, allowing w/c to roll backwards. (R91) stated 'I went to the bathroom and when I tried to get back in my chair I ended up here.'" The Report documented immediate action taken as "Maintenance notified of w/c brakes not properly functioning, Brakes fixed immediately."

There was no documentation in R91's medical record documenting the facility had a completed any type of assessment to determine the root cause of this fall related to her toileting self without staff assistance.

R91's Risk Management Note, effective date 12/7/18, documented "Resident on skilled OT (Occupational Therapy), D/C's (discontinued) from skilled PT on 12/6/18. On restorative programs. Mobile ad lib via W/C. Transfers, toilets self. Frequently reminded and educated on safety issues, expresses understanding. Will continue to monitor and assist as needed. Staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010227	A. BUILDING _____ B. WING _____	04/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASEYVILLE NURSING & REHAB CTR	601 WEST LINCOLN AVENUE CASEYVILLE, IL 62232

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4	S9999		

has noted an increase in confusion past couple days with accusatory remarks. MD notified with new orders to obtain urinalysis (UA). D/c' d (Discontinued) Lorazepam and decrease Trazodone to ½ tab daily. Will continue to monitor behaviors."

R91's Fall Investigation Report, dated 12/15/18 at 10:00 AM, documents "Resident found on floor in E hall bathroom. Sitting on floor with back up against the wall and wheel chair in front of her." The report documented the Immediate Action Taken as "Resident lifted off the floor with the assist of three. Assessed for injuries. (R) leg slightly rotated. Physician and POA (Power of Attorney) both notified. Order received for STAT (R) hip and pelvic x-ray. C/O (Complaints of) pain to RLE (right lower extremity), PRN (as needed) pain med administered." The report documented "Resident went to the restroom on her own without asking for assistance."

R91's Health Status Note, dated 12/15/2018 at 6:21 PM documents "Received x-ray results. Results show positive for Rt hip fx (fracture). Notified Doctor notified. New Orders (N. O's) to send out to the emergency room."

R91's Risk Management Note, effective date 12/20/19, documents "Resident has been noted with increased agitation, and paranoid behavior with restlessness. MD made aware with new orders for Urinalysis (UA) with positive results for UTI (Urinary Tract Infection) with initiation of ABT (antibiotics). MD also made adjustments to her RX (prescriptions) including discontinuing her Lorazepam decreasing her Trazodone prior to fall. Resident mobile via W/C with assist with transfers and toileting but frequently transferred and toileted self."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010227	A. BUILDING: _____ B. WING _____	04/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASEYVILLE NURSING & REHAB CTR	601 WEST LINCOLN AVENUE CASEYVILLE, IL 62232

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 5	S9999		

R91's Care Plan Focus, undated, documented "(R91) has impaired cognition, right hip fracture following a fall impaired mobility, incontinent of urine, receives medications daily that increase her risk and has a history of falls, she remains at risk. She requires extensive assist x 1-2 for ADL's (Activities of Daily Living) transfers, bed mobility and toileting. Assist x1 for perineal care and brief/linen change after each incontinent episode. She utilizes her w/c as her primary mode of transport. Poor safety awareness with cues for safety, noncompliant with asking staff for assist with transfers. Frequent reorientation of use of call light with education /encouragement on importance of asking staff for assist to prevent fall/injury, understanding not verbalized." The Care Plan documented an undated intervention "Ensure the residents call light is within reach and encourage the resident to use it for assistance as needed." This Care Plan goal was not revised as R91's fall were related to her getting up without assistance and how staff should address this issue to prevent future falls. The Care Plan goal, undated, documented "Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family /caregivers/ IDT (Interdisciplinary Team) as to causes."

On 4/18/19 at 11:11 AM R91 stated, "I think I have only fallen here two or three times, they tell me to use the light but when I do I have to wait, and wait, and wait, so I just take myself."

On 04/19/19 at 9:42 AM, V2, Director of Nurses (DON), stated that residents are toileted every two hours and as needed and believes the CNA's were toileting R91 every two hours at the time of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010227	A. BUILDING _____ B. WING _____	04/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASEYVILLE NURSING & REHAB CTR	601 WEST LINCOLN AVENUE CASEYVILLE, IL 62232

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 6	S9999		

her falls. V2 further stated that she would expect the CNA's or Nurses to toilet any resident when needed

R47's Electronic Health Record (EHR), dated 04/01/19, documents R47 has diagnoses (in part) Muscle Weakness, Osteoporosis, Repeated Falls, and Fracture of the Left Femur.

R47's MDS, dated 7/11/18, documented his Brief Interview of Mental Status score (BIMS) as 7, indicating severe cognitive impairment.

R47's Care Plan Interventions, dated 7/12/18, documented "Place resident at nurses' station if restless at night, and refuses to lay down for closer supervision," and "Remind res (resident) to allow staff to assist him. Uses w/c (wheelchair), stands frequently using w/c to balance, and unsteady at times."

R47's Reporting Form, dated 07/14/18 at 2:15 AM, documented R47 was found on the floor next to his wheelchair on B hall. The Form documented R47 complained of pain to the left side of his head, which was red without swelling. The report documented bed alarm, and wheelchair alarm was not in place.

R47's Clinical Care Plan Detail Report, documented Intervention, dated 7/14/18, as "Staff to ensure w/c/bed (wheelchair/bed) mat alarm are in place and in working order q (every shift and prn (as needed)."

R47's Reporting Form, dated 09/05/18, documents R47 was found on the floor in his room by physical therapy. The form documented R47 had no injuries. The Form documented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010227	A. BUILDING: _____ B. WING _____	04/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASEYVILLE NURSING & REHAB CTR	601 WEST LINCOLN AVENUE CASEYVILLE, IL 62232

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 7	S9999		

"Re-educate resident on safety. Call light c (with) in reach (and) remind, educate resident to use it." This report did not document if R47's wheelchair, and bed alarm were in place and sounding at time of this incident.

R47's Clinical Care Plan Detail Report, intervention date of 9/5/18, documented "Re-educate (R47) on safety, and encourage use of call light.

R47's Reporting Form, dated 09/11/18, documented a noise was heard in R47's bathroom and R47 was sitting on the floor in the bathroom in front of the toilet. The Form documented R47 had an abrasion to the center of his forehead and to the left side of his hand. On the bottom of the form documented R47 was impatient-impulsive and refused to use call light for assist. The form documented "will continue to educate resident on safety. Will assist as needed and as he allows." The report documented R47 had wheelchair and bed mat alarms but removes them at times. The report did not document if R47's alarm was sounding when this incident occurred.
R47's Reporting Form, dated 09/12/18, documents R47 was found on the floor in front of his wheelchair coming from the bathroom. The Form documented he sustained no injuries. The Report Form documented that R47 remains noncompliant and "continually educate resident on safety issue and is aware of such but chooses his independence - seldom uses call light for assist. Toilets, transfers per self." The Form did not document if R47's wheelchair alarm was sounding.

The Clinical Care Plan Detail Report, intervention date of 9/12/18, documented "Staff to assist to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010227	A. BUILDING: _____ B. WING _____	04/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASEYVILLE NURSING & REHAB CTR	601 WEST LINCOLN AVENUE CASEYVILLE, IL 62232

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 8	S9999		

bathroom upon rising, before and after meals, and before bed."

R47's Reporting Form, dated 11/24/18, documents R47 was found lying on the floor next to his closet. The form documented R47 was undressed from the waist down, and R47's wheel chair was next to his bed. R47 did not have on shoes or socks. The Form did not document if R47's wheelchair alarm or mat alarm was sounding at the time of the fall. The Form documented he complained of pain to his left hip and he was transported to the Hospital Emergency Department.
R47's Radiology Report dated 11/24/18 documents R47 has a fracture to the left proximal Femur.

The Clinical Care Plan Detail Report, intervention dated 11/24/18, documented "Place on gripper socks when in bed."

The Care Plan, intervention dated 11/28/18 documented "Ensure personal alarms are in place and in working order q (every) shift and PRN (as needed."

The Change in Positioning Device, dated 1/4/19, documented resident was placed in a specialized wheelchair with anti-roll back system and anti-tippers.

R47's Reporting Form dated 01/19/19 documents R47 was found lying on the floor in front of his wheelchair, no injury at this time. The Reporting form documented that R47 was noncompliant, stands from wheelchair and attempt to independently transfers. The report documented he has a wheelchair alarm but did not document if it was sounding at the time of this incident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010227	A. BUILDING: _____ B. WING _____	04/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASEYVILLE NURSING & REHAB CTR	601 WEST LINCOLN AVENUE CASEYVILLE, IL 62232

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 9	S9999		

The Clinical Care Plan Detail Report documented intervention dated 1/19/19 as "Skilled therapy has placed resident in w/c with dumped seat, anti-roll back system and anti-tippers with pressure cushion to provide optimum safety." This intervention was implemented prior to the incident on 1/9/19.

R47's MDS, dated 2/8/19, documents R47's BIMS score as 11, indicating moderate cognitive impairment. The MDS documented R47 requires extensive assistance of one person for transfers. R47's MDS also documents R47's balance for moving from a seated to a standing position, surface to surface and moving on and off toilet is not steady and R47 is only able to stabilize with staff's assistance.

R47's Reporting Form dated 03/30/19 documents R47 slid out of his wheelchair to the floor. The Form documented R47 was kicking his feet on the wall. No injury was noted.

The Clinical Care Plan Detail Report documented intervention dated 3/30/19, "resident is very restless and 'fidgety.' Staff continue to remind resident to sit down when in w/c. When in bed, continually attempts to get up, has electric high low bed with concave mattress with bolsters and floor mat. Staff to place at Nurse's station monitoring when up to w/c and redirect as needed."

On 04/19/19 at 10:30 AM V2 stated " Yes I would expect the resident to have progressive interventions."

On 4/16/19 at 9:49 AM. R84 stated "That's why I hurt so bad. I fall a lot. They took my walker away

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010227	A. BUILDING _____ B. WING _____	04/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASEYVILLE NURSING & REHAB CTR	601 WEST LINCOLN AVENUE CASEYVILLE, IL 62232

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 10	S9999		

and gave me a wheelchair."

R84's MDS dated 3/13/19 documents, in part, a BIMS score of 14, indicating she is cognitively intact, and documents she requires limited assist of one person for transfers and ambulation. The same MDS documents R84 is not steady during transfers but is able to stabilize without staff assist and that she uses both a walker and wheel chair for mobility.

R84's fall report dated 7/3/18 documents that R84 was found on floor in her room near the bathroom door and that there were no injuries from this fall. The "Nurse Investigation of Fall" dated 7/3/18 documents that R84 did not lock the brakes on her wheel chair before getting into the wheelchair.

R84's fall report dated 9/5/18 documents that R84 was observed sitting on the floor in front of the commode, and that R84 stated she took herself to the bathroom and slipped. The fall report documented there were no injuries from this fall. R84's fall report dated 9/13/18 documents R84 was found lying on her bedroom floor, and that R84 stated that she fell out of her chair while reaching for her call light on her bed. The fall report documents R84 had no injuries or bruising at the time of the fall, and that her Range of Motion was within normal limits. On 9/14/18 R84 began complaining of pain to groin and left hip and was diagnosed with fracture inferior pubic ramus.

On 4/19/19 at 10:20 AM V14,Care Plan Coordinator(CPC) provided interventions that had been put in place at the time of R84's falls: 7/3/18-ensure w/c (wheel chair) brakes are locked before sitting; 9/5/18- Oriented to call light on inside of the bathroom and encouraged to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010227	A. BUILDING _____ B. WING _____	04/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASEYVILLE NURSING & REHAB CTR	601 WEST LINCOLN AVENUE CASEYVILLE, IL 62232

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 11	S9999		

utilize for calling staff for assist.;
9/13/19-Intervention on care plan dated 9/13/19 documents, "Neuro checks initiated. Face checks per facility protocol. Sent to ER (Emergency Room) for eval and tx (treatment) but did not include a progressive intervention to decrease the risk of R84 experiencing further falls.

R84's fall report dated 9/13/18 documents R84 was found lying on her bedroom floor, and that R84 stated that she fell out of her chair while reaching for her call light on her bed. The fall report documents R84 had no injuries or bruising at the time of the fall, and that her Range of Motion was within normal limits. On 9/14/18 R84 began complaining of pain to groin and left hip and was diagnosed with fracture inferior pubic ramus.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010227	A. BUILDING: _____ B. WING _____	04/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASEYVILLE NURSING & REHAB CTR	601 WEST LINCOLN AVENUE CASEYVILLE, IL 62232

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 12	S9999		

on inside of the bathroom and encouraged to utilize for calling staff for assist.;
9/13/19-Intervention on care plan dated 9/13/19 documents, "Neuro checks initiated. Face checks per facility protocol. Sent to ER (Emergency Room) for eval and tx (treatment) but did not include a progressive intervention to decrease the risk of R84 experiencing further falls.

On 4/19/19 at 9:45 AM V2, DON, stated she would expect there to be progressive interventions put into place after a resident fall to prevent further falls, and care plan should be updated with these progressive interventions.

The Facility's policy, "Fall Prevention Protocol" dated 9/1/05, documents "Care plans for any resident experiencing a fall event will be updated to reflect the fall, any newly identified risk factors, and interventions designed to prevent reoccurrence. Residents who experience falls will be referred to the safety committee for further evaluation, analysis, and intervention implementation."

b. Based on observation, and interview the facility failed to ensure chemicals are stored in areas which area inaccessible to residents. This had the potential to affect one of one resident (R79) who was cognitively impaired and independently mobile using a wheelchair in a sample of 54.

Findings include:

The Minimum Data Set (MDS) dated 3/4/2019 documents R79's is severely impaired cognitively, has no functional limitation to her lower extremities, has a wheelchair, and a diagnosis of Non-Alzheimer's Dementia.

On 04/16/19 at 10:42 AM there was a canister of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010227	A. BUILDING _____ B. WING _____	04/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASEYVILLE NURSING & REHAB CTR	601 WEST LINCOLN AVENUE CASEYVILLE, IL 62232

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13 Bleach Germicidal Wipes on R79's bedside table. On 04/16/19 at 10:47 PM R79 was in her room sitting in her w/c talking to her roommate. On 04/19/19 at 12:30 PM R79 was propelling herself in the main hallway. On 04/16/19 at 10:49 AM V6 Licensed Practical Nurse (LPN) saw the canister of Bleach Germicidal wipes and removed it from the dresser stating that it shouldn't be there, and she doesn't know who put it there. On 04/19/19 at 9:28 AM V2 DON stated that the Bleach Germicidal Wipes should not have been in R79's room. The facility policy on Housekeeper Job Description undated documents under, "Duties # 10 Perform terminal cleaning procedures as directed, when a resident is discharged and/or transferred to another room. #18 Assure that adequate housekeeping supplies are maintained in utility/janitorial closets. In part." (B)	S9999		