(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		A. BUILDING:		R-C			
		IL601022	27	B. WING			4/2024
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CASEYVII I F NURSING & REHAB CTR				T LINCOLN A LLE, IL 6223			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S 000	Initial Comments			S 000			
	First Complaint Cerdate 1/2/24, Compl 23410227/IL16755	aints 23410338					
S9999	Final Observations			S9999			
	Statement of Licens	sure Violations	: :				
	300.610a) 300.1210b) 300.1210d)1)2) 300.1630d) 300.1630f)						
	Section 300.610 Re	esident Care P	olicies				
	a) The facility procedures governifacility. The written be formulated by a Committee consisti administrator, the a medical advisory conformities shall composition of the written policies the facility.	ing all services a policies and p Resident Care ing of at least the divisory physicion mittee, and er services in the ly with the Act a	procedures shall a Policy the prize procedures shall be procedured by the procedure of the				
	Section 300.1210 C Nursing and Person		ements for				
	b) The facility care and services to practicable physica well-being of the reeach resident's conplan. Adequate and care and personal of	II, mental, and p sident, in acco nprehensive re d properly supe	ntain the highest psychological ordance with esident care ervised nursing				

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 01/31/24

TITLE

STATE FORM 6899 If continuation sheet 1 of 8 2ESX12

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		SURVEY LETED
IL6010227		B. WING		R-C 01/24/2024		
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 0172	11202-1
CASEYV	ILLE NURSING & REI	HAB CTR	LINCOLN A			
240.15	CUIMMA DV CTA		LLE, IL 6223		ON	(2/5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 1	S9999			
	resident to meet the care needs of the re	e total nursing and personal esident.				
	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:					
	Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.					
	2) All treatments and procedures shall be administered as ordered by the physician.					
	Section 300.1630 A	Administration of Medication				
	d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's record.					
	f) Nurses' stations shall be equipped as per Sections 300.2860 or 300.3060 and shall have all necessary items readily available for the proper administration of medications.					
	These requirements by:	s were not met as evidenced				

Illinois Department of Public Health

STATE FORM 2ESX12 If continuation sheet 2 of 8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
II 6040227				R-		
		IL6010227	B. WING		01/2	4/2024
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
CASEYV	ILLE NURSING & RE	HAB CTR	TLINCOLN A LLE, IL 6223			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	.D BE	COMPLETE DATE
S9999	Continued From pa	ige 2	S9999			
	medication availabl sustaining a fractur	e for her to take after ed shoulder.				
	Findings include:					
	R16's Face Sheet, not dated, documents R16's initial admit date as 7/26/2019 with Unspecified Displaced Fracture of Surgical Neck of left Humerus, Subsequent Encounter for Fracture with Routine Healing and Pain in right Shoulder. On 1/23/2024 at 4:40 PM, R16 has a sling on her					
	left arm and was sitting at the dining room table. When R16 would move her upper body, (R16's) eyes would close and she would display a facial grimace (eyes blinking and nose scrunching) and touch her shoulder with her opposite hand, then her face returned to normal and become stiffer in the upper body area and then relaxed and facial grimace disappeared.					
	supposed to have sordered on Friday be still have not gotten to take them for my pain. I am really has leeping, it just hurlenough nurses, esp. They gave me an (enough to help me bothering me, and understand why I mpain medication. The togo down and the that I am hurting."	43 PM, R16 stated, "I was some pain medications out today is Tuesday and they a them for me. I am supposed y pain. I have been in a lot of ving problems moving, ts. I do not think they have becially on the weekends. accetaminophen) but it is not with this pain, and it is really I have been suffering. I don't nust wait so long to get my nen it takes longer for the pain y do not seem to really care				
	was having excruci	25 PM R16 stated that she ating pain on 1/20, 1/21, 1/22 ad that on Saturday (1/20/24)				

Illinois Department of Public Health

STATE FORM 2ESX12 If continuation sheet 3 of 8

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE		
AND PLAN OF CORRECTION	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMP	LETED
IL6010227		B. WING		R- 01/2	.C 4/2024	
NAME OF PROVIDER OR SUF	PPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CASEYVILLE NURSING	& RE	HAB CTR	ΓLINCOLN A LLE, IL 6223			
PREFIX (EACH DEF	SUMMARY STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
level was 9 (a pain pill. R1 informed by tout and that the was given Tyle not touch here excruciating paths a with personal unspecified deleft humerus, with routine hadministration 2024 documents a with personal unspecified deleft humerus, with routine hadministration 2024 documents 5-325 MG (mathetation to the following season of the fill of the floor with the fl	ng pai -10). 6 stathe number of the firm an Or diagn care, isplace ealing n Recents are illigrar rug*, eded for action and the firm or action alternation and the firm of the pain, responsible or action and the pain and the p	ge 3 n. R16 stated that her pain R16 stated that she asked for ed at that time she was se that her medication was suldn't get it. R16 stated she R16 stated that Tylenol does R16 stated that she was in I weekend. R16 stated that st dose on 1/23/2024. der Sheet dated 1/2024 osis of need for assistance pain in the right shoulder, ed fracture of surgical neck of equent encounter for fracture. R16's Medication ord (MAR) dated January order for Norco Oral Tablet ins), start date 1/5/2024, give 1 tablet by mouth every 6 or pain. Severe related to other at Set (MDS) dated ent she is moderately impaired ivities of daily living. Atted 11/21/2023 documents ation in musculoskeletal status in eneck of left humerus a fall trying to pick something in her way to the bathroom." In our Note dated 1/19/2023 at even today sitting in wo therapy gym. She admits to eccived her shoulder x-ray is subluxation of the shoulder. ER for evaluation/treatment.	S9999	DELIGITACITY		

Illinois Department of Public Health

STATE FORM 2ESX12 If continuation sheet 4 of 8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		A. BUILDING:						
		IL6010227		B. WING			-C 2 4/2024	
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
CASEYVI	LLE NURSING & RE	HAB CTR		TLINCOLN A LLE, IL 6223				
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
	Continued From particles and cooperative. She is Therapy) and OT (of to a decline in ability activities without phesordination, staticy postural alignment, mobility, training, Nore-education) and stasks. ROS (Reviewshoulder pain." R16's Progress Note PM, Note Text: "Reshoulder pain. NP (facility and gave veous ER (Emergency Roshoulder x-ray. Restransported via non Medical Services)." R16's Hospital Pap 7:26 PM, Chief Cor Patient sent to Emeshoulder dislocation after an impacted find fumerus." R16's Medication Con Sheet documents Fhydrocodone-aceta 5-325) medications R16's Progress Note documents "*Nursing placed to pharmacy script for resident Note V11, Nurse Practa a return phone call.	working with PT occupational the y to perform fundaysical assistance balance, dynaming pain, strength, for MRE (Neuromus killed intervention of Systems). For the state of the property of the state of the property of the pr	rapy) related ctional re, iic balance, functional scular ons for toileting Pleasant, left 024 at 6:44 ospital) for left rer) called the rend her to the rend her to the rend her to the result of the	S9999				

Illinois Department of Public Health

STATE FORM 2ESX12 If continuation sheet 5 of 8

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		E SURVEY PLETED	
		IL6010227	B. WING		I	R-C 24/2024
	PROVIDER OR SUPPLIER	HAB CTR 601 WE	NDDRESS, CITY, S ST LINCOLN A /ILLE, IL 6223	VENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
\$9999	Sheet documents F hydrocodone-aceta 5-325) medications R16's Medication A dated January 2024 her last dose of PR medication 5-325 m hydrocodone-aceta 5-325) on 1/20/202 and her pain was a scale with 0 being r severe pain). R16's MAR for pain R16 did not receive 5-325 mg hydrocod 1/21/2023 and 1/22 R16's MAR document MG, give 2 tablets in needed for general 9/9/2022 document acetaminophen on her pain was a 9 output for the service of the	R16 received a new card of minophen (Norco Oral Tablet on 1/23/2023 at 7:07 PM. dministration Record (MAR) decuments, R16 received N (as needed) paining minophen (Norco Oral Tablet 4 at 1:11 AM, in the morning n 8 out of 10 (pain severity no pain and 10 indicating management documents any PRN pain medication done-acetaminophen, on 1/2023. The section of the sect				
	(RN) stated, "I would medicine to be ordered medication runs out the resident for pair medication. We have the facility, and we running out and needs	40 PM, V4, Registered Nurse Id expect any resident's pain ered and available before the t and be available to give to n. (R16) did run out of pain we a physician who is new to had an issue with (R16) eding a script for the physician was delayed in age."				

6899

Illinois Department of Public Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:					
		IL60102	27	B. WING			-C 2 4/2024	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
CASEVV	ILLE NURSING & RE	HAR CTR	601 WES	LINCOLN A	VENUE			
OAGETV	ILLE NONOINO & NE	TIAD OTT	CASEYVI	LLE, IL 6223	32			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
S9999	Continued From pa	ige 6		S9999				
	On 1/24/2024 at 4:0 stated, "I would exporder for pain mediorders followed and resident is in pain a would expect the plif a resident is in pain medication it caccelerate and become on 1/24/2024 at 3:4 provided the Feder the facility's Pain Policy 1.0 states of the st	pect a resident cation to have the medication to have the medication orders in, and they do an cause the pome harder to the PM, V1, Ad al Critical Path	who has an the physician on given. If the lorder for pain, I s to be followed. o not get the pain to manage."					
	On 1/24/2024 at 4:3 does not have a pa		ted the facility					
	does not have a pain policy. The facility's medication administration general principles, revision date of 01/14/2020, documents "Policy: Medications will be administered in a safe, efficient, and accurate manner to residents for whom they are prescribed and in accordance with current acceptable nursing practice. Policy guidelines and interpretation: 1. Only individuals licensed or permitted by this state may prepare, administer, and document the administration of medication in this facility. 2. Medications must be administered as ordered by the physician." It further documents "6. Medications will be administered in accordance with the six (6) "Rights" e. Right Time: Administer medications as instructed on the MAR and in accordance with the physician's orders. As a general rule of thumb medications should be administered within one (1) hour of their scheduled time unless other instructions are given (e.g., before or after meals)." It also documents "14. If a drug is withheld, refused, given at a time other than the scheduled time, or not given for any other reason, the individual							

Illinois Department of Public Health

STATE FORM 2ESX12 If continuation sheet 7 of 8

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
IL6010227		B. WING		R-C 01/24/2024		
		IL6010227	B. WIIVO		01/2	4/2024
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CASEYV	ILLE NURSING & REI	HARCIR	T LINCOLN A LLE, IL 6223			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 7	S9999			
S9999	administering the m place the appropria the eMAR (electron record) which will in	ge 7 nedication shall initial and te chart code/follow up code in ic medication administration idicate the reason medication is ordered. A progress note				

Illinois Department of Public Health

STATE FORM 2ESX12 If continuation sheet 8 of 8