Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000970	A. BUILDING: ______ B. WING ______	C 05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASEY HEALTHCARE CENTER	100 N.E. 15TH CASEY, IL 62420

(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 Facility Reported Incident of 4/29/24/IL172848	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 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. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care 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	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000970	A. BUILDING: ______ B. WING ______	C 05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASEY HEALTHCARE CENTER	100 N.E. 15TH CASEY, IL 62420

(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		

nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
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.

These Regulations not met as evidenced by:

Based on interview and record review, the failed failed to provide appropriate fall interventions and keep equipment out of the hallways for one of three residents (R1) reviewed for falls on the sample list of 12 residents. Failing to ensure R1 was wearing appropriate footwear resulted in R1 falling and sustaining a laceration that required sutures.

Findings include:

R1's undated Cumulative Diagnosis Log documents R1's diagnoses as: Agitation due to Dementia, Major Neuro Cognitive Disorder, and Alzheimer's Disease probable with Behavioral Disturbances.

R1's Nursing Admission Assessment documents R1 admitted to the facility on 4/12/24.

R1's Fall Risk Assessment dated 4/12/24, documents R1 as a high fall risk.

R1's Minimum Data Set dated (MDS) dated 4/19/24, documents R1 has disorganized thinking and an altered level of consciousness. This same MDS documents R1 has had falls prior to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000970	A. BUILDING: ______ B. WING ______	C 05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASEY HEALTHCARE CENTER	100 N.E. 15TH CASEY, IL 62420

(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		

admission to the facility.

R1's Psychosocial Assessment dated 4/19/24, documents R1 is easily distracted, is forgetful, has short and long term memory problems, wanders and paces, agitated, and has severe impairment with decision making and problem solving.

R1's AIM (Assess, Intercommunicate, Manage) for Wellness report dated 4/28/24 at 10:30 AM, documents a crash was heard and down the hallway and R1 was lying next to a mechanical lift, R1 was on R1's right side, R1 sustained an abrasion to R1's right elbow.

R1's Nursing Progress Note dated 4/28/24 at 12:30 PM, documents R1 has been up walking the halls.

R1's AIM for Wellness report dated 4/28/24 at 4:00 PM, documents a witnessed fall.

R1's Nursing Notes dates 4/28/24 at 6:20 PM, documents an order for blood draws and a urinalysis for repeated falls.

R1's AIM for Wellness report dated 4/29/24 at 10:20 AM, documents R1 fell in the hall while ambulating independently, was not witnessed, assessed and found bleeding from a head injury and a small laceration on outer left eyebrow. This same report documents R1 was transported to the hospital.

R1's Emergency Documentation notes dated 4/29/24, document a two centimeter linear laceration above the left eyebrow which was repaired with three sutures in the emergency room. R1's also had a diagnosis of a fall as a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000970	A. BUILDING: ______ B. WING ______	C 05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASEY HEALTHCARE CENTER	100 N.E. 15TH CASEY, IL 62420

(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		

reason for this same visit.

R1's Care Plan dated 5/1/24, documents the intervention for one fall on 4/28/24, to educate staff to keep hall clear and free of clutter; for the second fall on 4/28/24, to obtain a CMP (complete metabolic panel), CBC, (complete blood count) and a urinalysis (UA); for the fall on 4/29/24 to ensure appropriate footwear; and for a fall on 5/1/24, medication review requested.

On 5/14/24 at 3:45 PM, V6 Licensed Practical Nurse (LPN) stated R1 wanders around the building. V6 stated R1 walks around a lot and wears gripper socks mostly during the evening and V6 does not know what other shoes R1 has. V6 stated that on 4/28/24, R1 was doing normal wondering and R1 was by the back door by the weight scale and one foot hanging off but R1 was trying to sit on the ground and lost her balance and fell on her bottom and was leaning over to R1's left elbow holding her up.

On 5/14/24 at 1:22 PM, V3 Certified Nursing Assistant (CNA) stated R1 was walking like R1 normally does and she sometimes looks down when walking and we cue her to look up. V3 stated V3 passed R1 and was helping another resident and does not know if R1 had shoes on or what shoes they were. V3 stated R1 has slip on shoes and some slide sandals that are plastic and not safe to wear and there is no back on her shoes.

On 5/14/24 1:40 PM, V1 Administrator stated R1 had a pair of sandals with a big wide band across the top and no straps in the back and a pair of slip on tennis shoes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000970	A. BUILDING: ____ B. WING ____	C 05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASEY HEALTHCARE CENTER	100 N.E. 15TH CASEY, IL 62420

(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		

On 5/14/24 at 3:15 PM, V5 Licensed Practical Nurse stated R1 has a pair of slip on tennis shoes with no laces and no back and a slipper sock thing with no back on it and it has a plastic sole. V5 stated R1 would be so tired from walking but would keep going that's when V5 thought R1's shoes might not be good. V5 stated she does not remember what if anything was on R1's feet when she fell that time.

On 5/14/24 at 2:46 PM, V2 Director of Nursing (DON) stated R1 has a pair of tennis shoes which are slip-ons with no back and also wears a pair of yellow slippers with no back. V2 stated R1's husband was called after R1's fall from 4/29/24 so he could bring in another pair of shoes. V2 stated this was an intervention after that fall. V2 stated this should have been an earlier intervention because R1's shoes were not really safe. V2 stated R1 ran into a mechanical lift that was in the hallway on 4/28/24 which was not supposed to be there because it is a hazard. V2 stated the urine should have been obtained as soon as possible after the order was given since the order was given after the second fall on 4/28/24. V2 confirmed the order for a UA was given on 4/28/24 and was not obtained until 5/2/24.

The facility's Fall Prevention Policy dated Revised 11/10/18, documents this policy is to provide for resident safety and to minimize injuries related to falls.

(B)