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 _____	C 02/14/2025

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

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S 000	Initial Comments Complaint Investigations: 2540983/IL185950 2541051/IL186009 Facility Reported Incident of 2/10/25, IL186250	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1220b)3) 300.3210t) 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. 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	S9999		

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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.

300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition.

Section 300.3210 General

t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.
These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to prevent abuse in 2 of 8 residents (R4, R5) reviewed for abuse in the sample of 8. This failure resulted in R5 being scared and not feeling safe in the facility.

Findings include:

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1. On 2/14/25 at 8:25 AM, R5 stated recently R6 grabbed her by the arm and left bruises as she was walking by him. R5 stated staff didn't intervene right away but did come when she yelled out. R5 stated R6 resides on the same hall as her, she's scared and doesn't feel safe in the facility because of him (R6). R5 stated she wants to be moved off that hallway to get away from R6. R5 stated there haven't been any further incidents with R6 but she doesn't go near him.

On 2/14/25 at 12:55 PM, V1, Administrator, stated R5 and R6 either bumped into one another or grabbed ones arm. V1 stated she watched the camera footage and didn't see R6 grab R5's arm, they were just passing one another in the hallway. V1 stated R6 does have behaviors every day, yells/screams out and it gets on the other resident's nerves. V1 stated the other residents may want to hit him, but she hasn't seen R6 hit anyone else.

R5's Face Sheet, undated, documents R5 has an admitting diagnosis of Collapsed Vertebrae.

R5's MDS (Minimum Data Set) dated 10/21/25, documents R5 has a BIMS (Brief Interview of Mental Status) score of 15, indicating she is cognitively intact.

R6's Face Sheet, undated, documents R6 has a diagnosis of Vascular Dementia and Anxiety Disorder.

R6's MDS, dated 1/31/25, documents R6 has a BIMS score of 10, indicating he has moderate cognitive impairment.

R6's Progress Note, dated 11/18/24 at 2:03 AM, documents, "Aggressive behaviors noted this

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shift. Resident was cursing at staff, threatening to hit CNA. Resident was easily redirected. At this time resident is in bed resting calmly. Bed in low position, call light in place. No s/s (signs/symptoms) of distress noted, resident denied pain."

R6's Progress Note, dated 12/7/24 at 1:45 AM, documents, "Patient has gotten progressive aggressive toward another resident on 200 halls. He continues to go to resident room cursing at him and threating to fight him. Staff took him off the hall x 2 and he was kicking and holding to side rail and didn't want to go and saying, "I can go where I want to, and I will when I get ready". He was very nasty and verbally abusive to the staff. After bringing him to this room, he went down again and confronted the resident on 200 halls, holding on to his wheelchair and they both were separated by staff. He then was put in his room. Neither one of the residents were hurt."

R6's Progress Note, dated 12/7/24 at 10:10 AM, documents, "Patient has been aggressive this morning and yelling, using fouled language, balling up his fist at staff as to hit them, and refused to let staff help him. Patient has been up in wheelchair this tour."

R6's Care Plan, dated 4/15/24, documents R6 has a behavior problem, impaired cognitive function and a mood problem. There were not any interventions added after 1/11/24 on R6's care plan to address his aggression with other residents/staff to provide sufficient protection of the other residents from abuse.

The Final Report and Conclusion of Incident, dated 1/24/25, documents a comprehensive investigation was initiated and found that on

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1/24/25 at approximately 6:15 PM, at the nurse's station R5 told nursing that R6 had grabbed her arm while passing at the nurse's station. It was unwitnessed. Residents were immediately separated. R6 was moved into the hallway. Both residents were assessed with no injuries noted. V5 remains at baseline and shows no signs of mental anguish. The facility finds the allegation of willful abuse unsubstantiated. Both residents plans of care have been updated.

2. On 2/14/25 at 8:30 AM, R4 stated he had an agency CNA (Certified Nurse's Assistant), that came into his room and told him "She wasn't f***** cleaning him up, he could clean himself off and to f*** off." R4 stated he had feces on his hand and asked the CNA to clean him and his hand off and she refused. R4 stated he hasn't had that problem before, and other staff came in and took care of him. R4 stated the CNA hasn't been in his room or taking care of him and he doesn't leave his room, so he isn't sure if the CNA works in the facility anymore but "someone like her shouldn't be working anywhere with people." R4 stated he was "amazed/shocked when it happened, not scared, just shocked, that someone would talk and treat me like that."

R4's Face Sheet, undated, documents R4 has a diagnosis of Paraplegia.

R4's MDS, dated 1/17/25, documents R4 has a BIMS score of 15, indicating R4 is cognitively intact and requires substantial/maximal assist with toileting and is dependent with hygiene.

The Final Report and Conclusion of Incident, dated 2/10/25, documents a comprehensive investigation was initiated and found that on 2/10/2025 at approximately 8:45 AM, R4 advised

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a day shift agency CNA (V4) was being very unprofessional with him because he asked her to help get bowel movement off of his hands. R4 stated that the CNA refused to help him. The resident also had an audio recording of the Agency CNA cursing at him and refusing care. Administrator advised nurse to do an assessment. POA (Power of Attorney)/MD (Medical Doctor)/Police were notified. (V4) was DNR'd (Do Not Return) from facility. The Administrator also notified the licensing board about the agency CNA on the allegation of verbal abuse. There were no witnesses and none of the residents on the hall saw or heard anything out of the ordinary. R4 remains at baseline. The facility finds the allegation of willful verbal abuse substantiated.

V1, Administrator stated R4 had an audio recording of V4 cussing at him. V1 reported it to the agency V4 worked for and he was taken off their schedule and placed on the do not return to facility list. V1 stated she also reported the incident to the licensing board. V1 stated the allegation was substantiated.

The Abuse Prevention Program policy, dated 6/2008, documents the facility prohibits acts of mistreatment, neglect, abuse and/or crimes from being committed against it's residents. This facility desires to establish a resident sensitive and resident secure environment. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment, with resulting physical harm, pain, or mental anguish. Prevention of abuse will include resident assessment to ensure person-centered care approaches are individualized and communicated to facility staff.
(B)

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