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 _____	R-C 03/04/2025

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CASEYVILLE NURSING & REHAB CTR	601 WEST LINCOLN AVENUE CASEYVILLE, IL 62232

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S 000	Initial Comments First Recertification Revisit To Survey date 2/10/2025	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 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.	S9999		

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S9999	Continued From page 1 300.1220 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 observation, interview and record review, the facility failed to prevent resident to resident sexual abuse for 2 (R9, R10) of 4 residents reviewed for abuse in the sample of 4. This failure resulted in psychosocial harm in that, a reasonable person would react to such a situation with feelings of anxiety, distress, fearfulness and humiliation. Findings include:	S9999		

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R9's Undated Face Sheet, documents he was initially admitted to the facility on 10/1/2023 with diagnoses dementia, Alzheimer's disease and bipolar disorder.

R9's Annual Minimum Data Set (MDS) dated 2/10/2025 documents, BIMS 9.

R9's Undated Care Plan documents (R9) has impaired cognition, dementia, bipolar disorder, current episode manic without psychotic features. Interventions: distract resident from wandering by offering pleasant diversions, structed activities, food, conversation, television, books. Provide structed activities: toileting, walking inside and outside, reorientation strategies including signs, pictures memory boxes. R9 is a wanderer related to dementia. No interventions documented about resident found lying in other resident beds in the past or that he was found lying in bed with another male resident on 2/22/2025.

R10's Undated Face Sheet, documents he was initially admitted to the facility on 11/9/2022 with diagnoses dementia, Alzheimer's disease and anxiety disorder.

R10's Quarterly MDS, dated 2/4/2025, documents BIMS 4.

R10's Undated Care Plan, documents he is alert and orientated x2 and speech clear, usually can make needs known, dysphagia followed by cerebrovascular disease (stroke), dementia, anxiety disorder, Alzheimer's disease. R10's care plan not updated to a BIMS of 4 or that is currently non-verbal.

On 2/28/2025 at 12:10 PM V2, Director of Nurses (DON) stated they had a reportable on 2

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residents (R9) and (R10). "Staff found (R9) lying in bed with (R10) but they weren't touching one another or anything like that and staff redirected (R9) quickly and staff placed (R9) on a 1:1 for the rest of the night and frequent monitoring after that."

On 2/28/2025 at 12:30 PM V1, Administrator stated on 2/22/2025 at approximately 9:45 PM (R9) was found lying in bed with (R10). Neither resident is alert both are very confused and (R9) has a history of laying in other resident's beds but not while another resident is in bed. Staff redirected (R9) and skin checks were completed on both residents with no issues. Staff reported neither resident was touching one another. After (R9) was redirected, staff put him on a 1:1 for the night then frequent monitoring after that. No other incidents have occurred with (R9) before or after this incident.

R9's Alleged Abuse document dated 2/22/2025 at 9:40 PM, documents R9 unable to give description of what occurred. Statement: "(R9) was lying on the resident and appeared as if he was sleeping. His pants were down. R9 just looked confused. I told the nurse just in case and she called the administrator immediately. Immediate action taken resident made 1:1 during initial investigation. After investigation, the case for alleged abuse was unfounded. No injuries observed at time of incident. Mental status oriented to person only. Predisposing physiological factors: confused and impaired memory. Predisposing situation factors: Wanderer."

On 3/4/2025 at 8:50 AM V11, CNA stated she worked evening shift on 2/22/2025 from 2:00 PM to 10:00 PM and was assigned to (R10). V11

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recalled she was walking down (R10's) hallway and noted (R9) was laying on top of (R10) in (R10's) bed. V11 stated she immediately entered the room and noted (R9's) pants and adult incontinence briefs were down in the front and she could see genital skin but the room light wasn't on so she couldn't see if (R9's) penis was out or not. V11 told (R9) to get out of (R10's) bed. R9 stood up at that time. V11 couldn't recall if (R9's) penis was out when he stood up or if he pulled his pants up when he stood up. V11 stated she yelled for a nurse and V12, LPN (Licensed Practical Nurse) entered (R10's) room immediately. V11 reported what she saw to V12, and staff walked (R9) to his room and asked him what occurred. (R9) stated V11 was a liar and that he wasn't laying on top of (R10.) (R10) is non-verbal therefore he didn't say anything regarding (R9) laying on top of him. R10 had a blank stare.

On 3/4/2025 at 9:50 AM, V12 LPN stated she worked evening shift on 2/22/2025 from 2:00 PM to 10:00 PM and was assigned to (R10.) At approximately 9:40 PM V11, CNA yelled down the hall for a nurse. V12 stated she entered (R10's) room and noted (R9) was standing in (R10's) room and he had a t shirt and pants on. (R9) immediately stated V11 was lying, and it was "b*******". V11 reported to V12 that (R9) was found lying on top of (R10) in (R10's) bed and (R9's) pants were partially down. V12 stated V11 didn't say if (R9's) penis was out of his adult incontinence brief and V12 didn't ask additional questions as to what V11 saw when she initially observed (R9) laying on (R10.) V12 said staff walked (R9) back to his room and V12 did a skin assessment on (R10) with no abnormal findings. V12 stated (R10) was wearing a hospital gown and an adult incontinence brief when she did the

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skin assessment, and his adult incontinence brief was on and intact at that time. V12 stated (R10) is non-verbal and didn't respond to any of her questions regarding the incident. V12 stated, "(R10) wasn't crying or anything after (R9) left his room, he was just starring and then he went to sleep shortly after staff left his room".

On 3/4/2025 at 10:10 AM V13, LPN stated she worked evening shift on 2/22/2025 from 2:00 PM to 10:00 PM and was assigned to (R9.) V13 said V11, CNA came up to V13 at the nurse's station and reported that V11 just saw (R9) laying on top of (R10) in (R10's) bed and that (R9's) pants were partially down while he was laying on (R10.) V13 stated while V11 reported this to her, (R9) was observed walking toward the nurse's station from (R10's) hall. V13 stated she walked (R9) to his room and did a skin assessment on him, he had t shirt, adult incontinence brief and pants on at that time and there were no abnormal findings during the skin assessment. V13 interviewed (R9) and asked why he was found in (R10's) bed and (R9) replied it wasn't true and it was all "b*******". V13 stated (R9) is a wanderer but after that incident she told him to stay in his room and he did. V13 said she kept an eye on him until she left at approximately 11:00 PM.

R9's Progress note, dated 2/22/2025 at 10:35 PM documents, "This evening at 9:40 PM the CNA (Certified Nurse Assistant) assigned to the B hall noticed (R9) in bed on top of resident (R10.) The CNA stated that (R9) partially had his pants down while lying on top of the resident. This nurse assisted (R9) to his room, a body assessment was performed on him. No injuries were noted to his body. The administrator of this facility and the on-call nurse were all made aware of the incident. The police dept was called and 2 officers came

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out and made a police report. (R9's) son was called, there was no answer. A msg (message) was left for his son to call facility when he got this nurse msg. Physician was called and made aware of the incident. No new orders were received from physician."

R10's Progress Note, dated 2/22/2025 at 10:54 PM documents at "9:40 this evening this nurse notified by CNA that another male resident (R9) was found in the bed lying on top of (R10) with the other resident's (R9's) pants partially down. CNA stated she told the resident to come out of (R10's) room. This nurse did a full assessment of (R10's) body. Resident had no injuries found. This nurse then notified the Administrator of incident. Police were called and police report made. The physician called and notified of situation. POA called and notified of situation. ADON notified of situation".

Review of the facility investigation dated 2/22/2025 documents a comprehensive investigation was initiated and showed that staff reported the alleged victim (R10) with a BIMS of 4 (severely impaired) had alleged perpetrator (R9) BIMS of 9 (moderately impaired) in (R10's) room on top of him in his bed. Administrator/ADON/MD/POA/Police were all notified. Assessments completed on both resident no injuries noted. Both residents were immediately separated and redirected. Nursing staff increased rounds throughout the night to keep an eye out on both parties. A one on one was assigned to the alleged perpetrator (R9.) Upon interview neither resident could recall the incident or that even anything had been done. Neither resident shows any signs of psychosocial/mental anguish. Other residents were interviewed with no negative findings of

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anyone feeling unsafe. Alleged perpetrator (R9) has a care plan that shows he wanders and that he gets in other beds due to confusion. The allegation of willful physical abuse is unsubstantiated.

On 3/4/2025 at 8:15 AM V1, Administrator stated V12, LPN called her and stated (R9) was found lying in bed with (R10) and his adult incontinence brief was on, and no penetration occurred.

On 3/4/2025 at 8:20 AM V3, ADON stated V1 called her and stated to put a plan in place, so all the residents are safe. At first, V3 instructed V12, LPN to send (R9) to the hospital for psych evaluation but V12 stated (R9) wasn't agitated or anything so V3 stated to put him on a 1:1 with staff to ensure resident safety. V3 stated V12 reported that staff told V12 that (R9) was attempting to rape (R10). V12 reported that V11, CNA witnessed (R9) laying on top of (R10) in (R10's) bed and the front of (R9's) pants were down. V12 reported that V11 reported she saw (R9's) adult incontinence brief in the front but she didn't report seeing his penis out.

On 3/4/2025 at 8:40 AM V1 stated the investigation is completed and was unsubstantiated. V1 stated (R9's) care plan documents that R9 wanders about the facility, R9's never been sexual with residents in the past and he is very confused.

On 3/4/2025 at 9:15 AM R9 was sitting on the side of his bed. When asked about lying in bed with (R10) he stated, "It didn't happen and that it was all b*******".

On 3/4/2025 at 9:30 AM V14, family of (R10) stated, "H*** NO he wouldn't be OK with a male

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S9999	Continued From page 8 resident laying on top of him!" when questioned if he would be ok with a male resident laying on top of him. On 3/4/2025 at 9:45 AM R10 was observed sitting up in his wheelchair. R10 didn't respond to surveyor's questions regarding R9 laying on top of him. The facility's Abuse Prevention Program, revised 3/2018, documents Sexual Abuse is "non-consensual sexual contact of any type with a resident." Sexual abuse includes but is not limited to: unwanted intimate touching of any kind to the perineal area. (B)	S9999		