STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0039644	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASEYVILLE NURSING & REHAB CTR	601 WEST LINCOLN AVENUE , CASEYVILLE, Illinois, 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) COMPLETION DATE
S0000	Initial Comments Annual Licensure Health Survey	S0000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 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. 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	S9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0039644	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASEYVILLE NURSING & REHAB CTR	601 WEST LINCOLN AVENUE , CASEYVILLE, Illinois, 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) COMPLETION DATE
S9999	Continued from page 1 personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 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 requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure staff implemented existing accident prevention interventions and failed to review and revise interventions after changes in resident's condition in 3 of 4 residents (R5, R49, R36) reviewed for falls in the sample of 37. These failures resulted in R5 suffering multiple falls and right ankle fracture. 1. R5's Face sheet documents an admission date of 3/29/2021. Diagnosis include Displaced Comminuted Fracture of Shaft of Right Tibia, Chronic Obstructive Pulmonary Disease, Acute and Chronic Respiratory Failure, Chronic Kidney Disease. R5's Minimum Data Set, MDS, dated 6/16/2025 R5 is moderately cognitively impaired. MDS dated 6/20/2025 documents R5 requires partial to moderate assist with lying to sitting and sitting to standing. R5's care plan dated updated 6/19/2025 documents R5 is at risk for falls related to diagnosis of Chronic Obstructive Pulmonary Disease, Heart Failure, repeated infections, Weakness, Gout, Respiratory Failure, Pain, Obesity, difficulty walking, Rheumatoid Arthritis, visual disturbance, need for assistance with activities of daily living, ADLs, psychotropic medication use,	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0039644	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASEYVILLE NURSING & REHAB CTR	601 WEST LINCOLN AVENUE , CASEYVILLE, Illinois, 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) COMPLETION DATE
S9999	Continued from page 2 narcotic medication use, as needed oxygen use, history of falls, frequently chooses to sit edge of bed with legs dependent despite education, overestimates limits, declines to use call light at times. 1/16/2025 Anti-slip tape. 6/17/2024 Sign placed in R5's room to remind/encourage to call for assist. Nonskid to edge of mattress. R5's Morse fall scale dated 4/25/2025 documents R5 is at high risk for falls. R5's Morse fall scale dated 6/3/2025 documents R5 is at high risk for falls. R5's progress notes dated 5/15/2025 at 9:55PM documented, Bed alarm heard alerting and checked. R5 was found on the floor at bedside facing door. R5 has skin tear noted to left shin. Moderate amount of blood noted. R5 assisted up from floor with mechanical lift with multiple staff assist to ensure safety. R5 unable to state what happened. R5 unable to state if she hit head. R5 has history of warfarin. Services, EMS arrival. Management notified. R5's After visit summary dated 5/15/2025 documents diagnosis fall, initial encounter. Laceration of left lower extremity, initial encounter. Facility's final investigation dated 5/16/2025 documents: A comprehensive investigation was completed and found on May 16, 2025, at or around 9:55PM. R5 was noted to have sustained an unwitnessed fall in R5's room on the floor at bedside facing the door. Licensed nursing staff immediately assessed R5. Upon initial assessment R5 had a skin tear noted to left shin. R5 was unable to state what happened. Power of Attorney, POA, Physician, and V1, Administrator, were notified with an order to send R5 out to local Emergency Room, ER, for evaluation and treatment. ER contacted facility and advised that R5 had a laceration to the left shin. Upon return the facility will monitor for pain, and make appropriate notifications as needed. The facility has completed a root cause analysis, and appropriate interventions will be put into place and R5's plan of care will be updated accordingly. R5's progress notes dated 6/3/2025 at 12:27AM document, Registered Nurse, RN, notified by Certified Nursing	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0039644	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASEYVILLE NURSING & REHAB CTR	601 WEST LINCOLN AVENUE , CASEYVILLE, Illinois, 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) COMPLETION DATE
S9999	Continued from page 3 Assistant, CNA, that R5 was found lying on the floor next to her bed. Large amount of blood found pooled under her right lower extremity. Upon physical assessment, she (R5) has a large laceration to the right outer ankle that continues to have active bleeding. Two dressings applied with gauze and wrap compression dressing applied, this RN held site and controlled bleeding. EMS called. EMS arrived at 12:15AM and left with R5 via stretcher to local hospital at 1:27AM. Unknown if R5 hit her head. No other abnormalities or injuries noted. Neck and spine protected and maintained. R5 is alert and oriented times three with some confusion. Unable to state how she got on the floor or what she injured. R5 has red and purple discoloration to both lower extremities with generalized swelling plus two to both lower extremities. On call nursing management notified of incident at 12:37AM. R5's Emergency Room visit dated 6/3/2025 documents X-ray right ankle three or more views. Impression: Comminuted fracture of the distal tibial and fibular metaphysis. Small posterior malleolar fracture. Ankle mortise congruent. Facility's final investigation dated 6/3/2025 documents A comprehensive investigation was completed and found on June 3rd at or around 12:27AM. R5 was noted to have sustained an unwitnessed fall in R5's room. Licensed nursing staff immediately assessed R5. Upon initial assessment R5 stated her legs were restless and she needed to get out of bed. R5 complained of right ankle pain. Power of Attorney, POA, Physician and V1, Administrator, were notified with an order obtained to send R5 to local ER for evaluation and treat. Results of that X-ray were positive. All parties notified. R5 has an open fracture of right ankle. R5 is still in the hospital. No surgery at this time. When R5 returns the facility will monitor for pain and make appropriate notifications as needed. The facility will complete a root cause analysis, and an appropriate intervention will be put into place, and R5's plan of care will be updated accordingly. Facility's Root Cause Analysis dated 6/3/2025 documented Details: R5 observed on floor lying next to bed. Noted alarm sounding, matt in place. Bed noted in highest position. Assessment revealed compound fracture to right ankle with blood loss. Pressure applied and EMS notified. R5 at that time unable to say what happened. R5 not incontinent at time of incident. Root	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0039644	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASEYVILLE NURSING & REHAB CTR	601 WEST LINCOLN AVENUE , CASEYVILLE, Illinois, 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) COMPLETION DATE
S9999	Continued from page 4 cause: failing to call for assistance. Parties notified. Intervention: send to local hospital for evaluation. Will review for further interventions upon return. On 6/25/2025 at 9:45AM in R5's room, no call for assist signage posted, no nonskid tape on floor, no nonskid on bedside, and no mat on floor. Floor mat folded up on shelf. On 6/25/2025 at 9:45AM V11, Certified Nursing Assistant, CNA, stated, "(R5) used to be farther down the hall. She moved into this room about a month ago. I think her bed was just changed so the blue piece for sliding is not on the bed. The mat is usually down too." On 6/25/2025 at 10:00AM R5 sitting in hallway in wheelchair. R5 very drowsy. R5 stated, "I slipped in my room." On 6/25/2025 at 10:20AM V13, Certified Nursing Assistant Supervisor, stated, "The last fall R5 had she put her bed up in the air. I tried to tell the staff R5 would do that but with new staff coming in, not everyone knew. When asked how long R5 had been in (current room), V13 stated "Probably a month." On 6/25/2025 at 10:30AM V2, Director of Nursing, DON, stated, "R5 is our problem child. She refuses to use the call light and ask for help. What else are we supposed to do?" When surveyor asked V2 about nonskid tape, signage and nonskid not being put in R5's room, V2 stated "None of those interventions apply anymore, so why use them?" On 6/25/2025 at 10:30AM V3, Assistant Director of Nursing, ADON, stated, "We have all the interventions in place. There's not much else we can do." On 6/26/2025 at 10:15AM V20, Nurse Practitioner, NP, stated R5 takes her oxygen off a lot and gets hypoxic. V20 stated, "These are the times she tries to get up and gets hurt. I feel frequent rounding and making sure her nasal canula is in her nose is the best intervention."	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0039644	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASEYVILLE NURSING & REHAB CTR	601 WEST LINCOLN AVENUE , CASEYVILLE, Illinois, 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) COMPLETION DATE
S9999	Continued from page 5 -- 2. R49's Undated Face Sheet documents an admission date of 11/26/2024. Diagnosis include Hypertension, History of Falling, Lack of Coordination, Restlessness and Agitation, Dementia, and Alzheimer's Disease. R49's Minimum Data Set (MDS) dated 4/21/2025 documents R49 is severely cognitively impaired, needs substantial/maximal assistance with lying to sitting on side of the bed, sitting to standing, and chair/bed to chair transfers. R49's Undated Care Plan documents R49 is at risk for falls related to Unspecified Fracture of Lower End of Left Femur Closed Fracture with Routine Healing, History of Falls, Alzheimer's Disease, Unspecified Injury to the Head, Incontinent of Bowel and Bladder, Cognitive Communication Deficit, Other Abnormalities of Gait and Mobility, Anxiety. Intervention updated on 2/3/2025 documents non-skid to wheelchair to prevent slipping from seat and ensure wheelchair is locked prior to transferring. Intervention updated on 2/7/2025 documents obtained personal alarm to stay on resident to alert staff when resident attempts to ambulate without assistance. Intervention updated on 3/31/2025 documents resident used dump w/c for mobility. R49's Fall Scale Report dated 2/12/2025 documents R49 is a high fall risk. R49's Fall Scale Report dated 4/1/2025 documents R49 is a high fall risk. R49's Nursing Note dated 1/31/2025 at 2:25 PM documents: Resident attempting to ambulate from bed to wheelchair, without assistance. Resident fell on floor. Resident stated that she didn't hit her head. AOx2 (Alert and Oriented), complaint of (c/o) pain in her back, upper and lower extremities normal Range of Motion (ROM). Medical Doctor (MD) Notified, Power of Attorney (POA) Notified, Director of Nursing (DON) Notified. R49's Nursing Noted dated 2/2/2025 at 10:08 PM documents: Called to (R49) room, (R49) lying on left	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0039644	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASEYVILLE NURSING & REHAB CTR	601 WEST LINCOLN AVENUE , CASEYVILLE, Illinois, 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) COMPLETION DATE
S9999	Continued from page 6 side on floor in front of wheelchair (wc) in front of doorway, states she was scooting and fell out of wc, unsure how, mod amt brb noted from laceration to mid forehead, ice and pressure applied, (R49) c/o pain to head and left lower extremity (LLE), first aid applied and staff present, until Emergency Medical Service (ems) arrival, POA notified and will meet (R49) at hospital, MD notified, on call supervisor notified, report given to ems and (R49) leaving facility in route to local hospital. R49's Nursing Note dated 2/7/2025 at 1:04 AM documents (R49) found on floor beside bed bleeding from a head injury. Bleeding stopped, 5 cm laceration to the right side of forehead, 2.5 cm laceration above the right eyebrow, 2 cm laceration to the top of the nose, abrasion to the right upper face and eye. EMS called for emergency transport to ER, POA notified, (Assistant Director of Nursing) ADON notified, MD notified. R49's Nursing Note dated 3/10/2025 at 5:59 PM documents (R49) found on buttocks on floor beside bed, states fell while trying to get up, denies pain, ROM within normal limits (wnl), assisted to wc with staff of 2. neuro checks initiated pupils equal, round, and reactive to light (PERRL), hand grips/plantar pushes equal/strong, rom wnl, on call provider notified, on call supervisor notified, POA notified. The Facility's Un-Witnessed Fall Report dated 3/10/2025 at 5:00 PM documents: Nursing Description "Res found on buttocks on floor beside bed" Resident Description "Res states was trying to get out of bed, denies pain" Immediate Action Taken "ROM and skin assessed and wnl, vs wnl assisted to wc with staff of 2." No root cause analysis available for this fall. No new intervention implemented or documented on R49's Care Plan after this fall occurred. R49's Nursing Note dated 3/17/2025 at 8:15 PM documents: (R49) observed sitting on the floor near her bed and heater in her room. (R49) has no complaints of pain or discomfort. (R49) states she fell on her butt. Assessment began. Skin tear noted to left knee measuring 0.3 cm x 0.3 cm. Area cleaned with wound cleanser and bandage applied. No other injury to note at this time. (R49) assisted back to bed with gait belt. Call light operative and within reach. Will begin fall protocols.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0039644	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASEYVILLE NURSING & REHAB CTR	601 WEST LINCOLN AVENUE , CASEYVILLE, Illinois, 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) COMPLETION DATE
S9999	Continued from page 7 The Facility's Un-Witnessed Fall Report dated 3/17/2025 at 8:15 PM documents: Nursing Description " Resident observed sitting on the floor on her buttocks near her bed and heater." Resident Description "Said she fell on her butt." Immediate Action Taken "Resident assessed. Skin tear noted to left knee. Area cleaned and dressed. Vital signs WNL. No other injury to note at this time. Move all extremities with no complaints. Resident assisted back to bed with use of gait belt." No root cause analysis available for this fall. No new intervention implemented or documented on R49's Care Plan after this fall occurred. On 6/25/2025 at 10:47 AM R49 observed self-propelling in hallway, non-skid mat and chair alarm noted to wheelchair. R49 unable to answer questions appropriately. On 6/25/2025 at 10:54 AM V7, Licensed Practical Nurse (LPN), stated R49 is very confused and likes to get up and wander throughout the day/night. V7, LPN, denies knowing of any fall interventions that are in place for R49. On 6/25/2025 at 11:02 AM V2, Director of Nursing (DON), stated there are no root cause analysis to provide for R49's falls. On 6/25/2025 at 2:59 PM V15, Certified Nursing Assistant (CNA), stated R49 is 2 assist with transfers. V15, CNA, stated R49 does not use the call light when she needs any assistance with getting up. V15, CNA, stated she does not know of any fall interventions that have been put in place for R49. On 6/26/2025 at 10:09 AM V19, Restorative CNA, stated R49 requires an assistance of 2 staff members to get up and transfer. V19, Restorative CNA, stated if R49 was to try to get up on her own, R49 would fall. V19, Restorative CNA, stated the only fall intervention she knows R49 has in place is a chair alarm in R49's wheelchair. -- 3. R36's Face Sheet documents R36 was admitted to the	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0039644	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASEYVILLE NURSING & REHAB CTR	601 WEST LINCOLN AVENUE , CASEYVILLE, Illinois, 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) COMPLETION DATE
S9999	Continued from page 8 Facility on 1/25/21 with diagnoses including dementia and muscle weakness. R36's MDS dated 4/20/25 documented R36 was severely cognitively impaired, used wheelchair, and required substantial assistance with bed mobility and transfer. R36's Care Plan initiated 4/21/25 documents R36 is at risk for falls. R36's Fall Risk Assessment dated 3/31/25 documented R36 was at high risk for falls. R36's Progress Note dated 5/15/25 documents R36 fell near her bed in her room. R36's Fall Investigation dated 5/15/25 documents R36 had an unwitnessed fall next to her bed. R36 stated she slid off her bed onto the floor. The cause of R36's fall was R36 sitting too close to the edge of the bed. The intervention was addition of a (non-slip cushion) to R36's bed. On 6/25/25 at 9:15 AM, R36 was sleeping in bed in her room. There was no (non-slip cushion) on her bed. V8, Certified Nursing Assistant (CNA), V9, CNA, and V10, Licensed Practical Nurse (LPN) all stated they have never seen a (non-slip cushion) on R36's bed. On 6/26/2025 at 11:19 AM V2, DON, stated after every resident fall an intervention must be initiated immediately. V2 stated the Facility's Interdisciplinary Team will review the implemented intervention and determine if the intervention implemented is appropriate or needs adjusted. It is her expectation for an intervention to be implemented after every fall that occurs and for the resident's care plan to be updated with the new intervention. The Facility's "Accidents and Incidents" Policy updated 12/13/2024 stated "All incidents and accidents occurring at the facility will be reported, investigated, and tracked in accordance with the guidelines contained herein. Reports of findings will be forwarded to the Director of Nursing or Administrator." (B)	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0039644	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASEYVILLE NURSING & REHAB CTR	601 WEST LINCOLN AVENUE , CASEYVILLE, Illinois, 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) COMPLETION DATE
S9999		S9999		