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 09/05/2019

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 Investigation to Incident of 8/21/19/IL115399	S 000		
S9999	Final Observations Licensure Violations 300.610a) 300.1210b)5) 300.1210d)6) 300.3240a) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

care needs of the resident.
5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These regulations were not met as evidenced by:

Based on observation, interview and record review the facility failed to provide a safe environment and supervision to prevent an accident for one of three residents (R1) reviewed for accidents. These failures resulted in R1 falling from the van and sustaining two rib fractures.

Findings include:

The Physician Order Sheet dated 8/1/19 through 8/31/19 documents R1 has diagnoses of Chronic Obstructive Pulmonary Disease, Chronic Back Pain, Polyosteoarthritis and Bone Cancer.

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S9999	Continued From page 2	S9999		

The Minimum Data Set dated 8/19/19 documents R1 is severely cognitively impaired and requires supervision and set up assistance with transfers and locomotion.

The Care Plan updated 7/31/19 documents R1 has poor safety awareness and ignores safety standards.

The Final Report dated 8/28/19 documents "Summary: On August 21, 2019 (R1) received a fall that resulted in anterior lateral 9th and 10th rib fractures."

The Final Report documents V3 Activity Director, CNA (Certified Nurses Aide) stated "We had taken five residents on an outing. When we got back we were unloading residents from the van. Everyone that went was using the lift. I had just lowered the lift to unload a resident (R2) and had assisted (R2) through the facility door when I returned. I had not raised the lift yet as I had to get the previous resident (R2) out of the way. I heard (V4 CNA) yelling "No, No, No" and got to the back of the van in time to see (R1) fall from the van in (R1's) wheelchair. (R1) landed on (R1's) shoulders."

The Final Report documents V4 stated "We were unloading residents from out of the van from our outing. I put (R1) in (R1's) wheel chair and (R1) began to move (R1's self) towards the lift. I realized the lift wasn't up and (R1's) wheelchair began to tip backwards. I tried to hold onto (R1) but could not. (R1) fell backwards in (R1's) wheelchair onto the lift."

The Final Report documents R1 stated "the girl (V4) had just put me in my wheelchair and I started moving back to go on the lift, but the lift

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S9999	Continued From page 3 was not up and I fell back." The Radiology Report dated 8/21/19 documents R1's left ninth and tenth ribs are fractured. On 9/5/19 at 12:30 PM the rear wheelchair loading van was observed with V6 Transporter. The measurement of the distance from the floor of the van to the ground was 28 inches. On 9/4/19 at 12:10 PM, R1 was in R1's wheel chair moving the wheel chair back and forth with R1's foot. On 9/4/19 at 1:05 PM R1 was seated the R1's wheel chair and R1 was propelling R1's self in the hallway. On 9/4/19 at 10:40 AM, V4 stated (on 8/21//19) V4 and V3 were on a pontoon boat outing with residents. V4 stated when they returned to the facility in the van, V3 and V4 were unloading residents from the van using the wheelchair lift. V4 stated V4 transferred R1 from the van seat to R1's wheelchair and V4 locked the wheels of R1's wheelchair. V4 stated R1's wheelchair was about two feet from the edge of the van floor. V4 stated V4 turned V4's back to grab something and when V4 turned back to R1, R1 was moving R1's feet to go backwards onto the ramp but the ramp was not raised and R1 fell. V4 stated R1 must have unlocked the wheel chair brakes. V4 stated they were having the same problem with R1 on the pontoon boat. V4 stated R1 kept unlocking the wheelchair wheels and moving the wheel chair back and forth on the boat. V4 stated they kept relocking the wheels and asking R1 to stop unlocking them but R1 kept unlocking the wheelchair wheels.	S9999		

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S9999	Continued From page 4 On 9/4/19 at 11:00 am V3 stated V3 had taken another resident (R2) off the van with the wheelchair lift and left the lift in the down position while V3 propelled R2 to the facility. V3 stated V3 was at the facility door when V3 heard V4 yelling. V3 stated V3 came around the side of the van and saw R1 falling out of the van in R1's wheelchair. V3 stated R1 fell on R1's shoulder area. V3 stated V3 would normally raise the lift before stepping away from the van. On 9/4/19 at 11:35 am V1 Administrator stated it is safer to always have the lift in the raised position on the van. V1 stated the policy now is to always raise the lift before walking away even if no residents are left on the van. On 9/4/19 at 2:40 PM V5 Physician stated staff should not leave anyone where they can fall. V5 stated someone should have been with R1 so R1 could not move while R1 was in the wheelchair on the van. V5 stated V5 could see how R1 might try to push things along so R1 could get off the van. V5 confirmed R1 fractured two ribs when R1 fell out of the van. (A)	S9999		