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 _____	03/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASEYVILLE NURSING & REHAB CTR	601 WEST LINCOLN AVENUE CASEYVILLE, IL 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) COMPLETE DATE
S 000	Initial Comments Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610a) 300.1210b) 300.1210d)3)6) 300.1220b)2)3) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3)Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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 300.1220 Supervision of Nursing Services b)The DON shall supervise and oversee the nursing services of the facility, including: 2)Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 3)Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs	S9999		

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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. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met evidencded by:

Based on observation, interview, and record review, the Facility failed to ensure restraints were evaluated, monitored, and ordered by the physician for 2 of 2 residents (R1, R12) reviewed for restraints in the sample of 54. This failure resulted in R12 being bed bound in her room, unable to move freely, causing her be fearful, tearful, and yelling out.

Findings include:

R12's Physician Order Sheet (POS) for February 2021 documents a diagnosis of Alzheimer disease, difficulty in walking, unspecified dementia without behavioral disturbances and anxiety.

R12's Minimum Data Set (MDS) dated 12/2/2020

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S9999	Continued From page 3 documents R12 was severely impaired for cognition status. On 2/24/21 at 7:40 AM, R12 was screaming from her room, "Help, me, help me they are holding me hostage, help me. Help me." On 2/24/2021 at 7:45 AM, R12's room was off of the nurse's station and the doorway of her room was covered with a thick plastic cover with a zipper in the middle of the door. The plastic was not clear and R12 was not able to be seen or observed through the plastic. R12's room was not on the COVID unit. On 2/24/21 at 8:01 AM, R12 was screaming "Please help me, help me, somebody please help me. I want out, I want out of here, can you please help me." Tears were running down R12's face and she pleaded for help. R12 stated she was weak and could not move around in her room without her wheelchair. On 2/24/2021 at 8:32 AM, R12 was screaming, "Help me, help me, can anybody just help me?" On 2/24/2021 at 9:03 AM, R12 was still screaming for help and asking for someone to help her. On 2/24/2021 at 9:10 AM, V8, Certified Nursing Assistant (CNA) stated (R12) was on contact isolation and her wheelchair was not in her room and she was not sure where (R12's) wheelchair was at. V8 also stated (R12) was weak because she had just returned from the hospital. On 2/24/2020 at 9:11 AM, V9, CNA stated (R12's) wheelchair was not in her room, she would check to find out where it was.	S9999		

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On 2/24/2021 at 9:12 AM, V2, Director of Nursing (DON), stated "(R12) just returned from the hospital and was on droplet precautions because of COVID pending. (R12) was not on the COVID hall because she was a fall risk and they wanted to move her closer to the nurse's station that is why she is on the 100 hall and on droplet precautions. The plastic is because of COVID."

On 2/24/2021 at 10:34 AM, V6, Licensed Practical Nurse (LPN), stated, "Yesterday (R12) was sleeping all day. She just came back from the hospital and she attempted to try and climb out the window, and elope and so we moved her near the nurses' station even though she is on contact isolation for COVID precautions. (R12) has been yelling today, but honestly, I do not know what to do. We are keeping her wheelchair out here in the hallway because I am afraid if she gets in her wheelchair then she will have a fall, so I think she is safer in bed. She likes to go to the window and try and climb out. She is doing a lot of yelling today. Her daughter does not want her on medicine. She is scared and cannot get out of bed, but I worry about a safety issue. I just don't know what to do with her. If we keep her out of her wheelchair and in bed, then I know she is safe."

2/24/2021 at 10:44 AM, V20, Nurse Practitioner stated, "(R12) just got back from the hospital so I have not seen her yet today. If a resident is yelling for help, I would expect staff to do one on ones with them to calm them down and make sure everything was okay until we could figure out a plan for them."

On 2/24/2021 from 7:40 AM to 10:44 AM based on 15 minute or less observation intervals, no

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staff entered R12's room or spoke with R12 when she was crying for help.

R12's undated Care Plan documents, "Resident has history of depression and can exhibit to becoming withdrawn. Resident can become confused at times and attempt to leave the building without supervision." R12's Care Plan, dated 8/15/19, documents, "Continuous attempts to leave out of building without assist. Therapy staff reported resident falling while going out of door unsupervised. Fell on left side and rolled over onto stomach. Assessment complete and Range of Motion performed. No complaints pain or injuries noted at this time. Resident states 'I just wanted to go for a walk'." R12's Care Plan does not document any attempts of her trying to climb out of the window. R12's Care Plan does not address R12's need for quarantine, how it would be implemented, or removal of her wheelchair.

R12's Care Plan dated 3/26/2020 document "(R12) is at risk for alteration in Psychosocial well-being related to restriction on visitation related to COVID-19" The Interventions documented were "Encourage alternative communication with visitors. Monitor for psychosocial changes. Observe and report changes in mental status caused by situational stressor. Provide opportunities for expression of feelings related to situational stressor. Redirect resident and encourage resident to engage in another activity other than leaving the building. Take resident out with supervision when weather permits. Will encourage resident to express her needs and feeling with others." R12's psychosocial well being was not being evaluated or monitored as she was yelling out for help.

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S9999	Continued From page 6 R12's medical records did not include any information in the assessment, physician orders, or care plan related to not being able to have her wheelchair in her room or why she had to be left in her bed, or R2's screaming, and feelings of being alone in her room. The Facility's Resident Census and Condition of Residents, CMS 672 Form dated 2/23/2021 documents there are no restrains in the Facility. The Restraint Policy with a Revision/Review date of 05/24/2017 documented, "The long term care facility supports a restraint-free environment. Whenever it is necessary to use selective restraints, the purpose will be to enhance the resident's quality of life by promoting safety and an optimal level of function. Restraint will be used only to treat medical symptoms. The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Prior to initiating a restraint, the resident will be evaluated for its use with the Primaris 3/09, 'Device Decision Guide: Restraint, Enabler, and Safety Hazard'." 2. R1's MDS dated 2/6/21 documents R1 requires extensive assist of two staff members for transfer, and bed mobility. R1's MDS also documents for moving on and off the toilet, surface to surface moves, and moving from a seated to standing position R1 can only be stabilized with the help of the staff. R1's POS dated 2/25/21 documents, May use 4 point positioning device while up in chair for safety and positioning.	S9999		

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R1's Electronic Health Record, reviewed on 2/23/21, had no order for the 4 point positioning device.

R1's Morse Fall Scale dated 11/5/21 documents R1 has a score of 75, which is a high risk for falls.

R1's Fall Care Plan dated 11/5/20 with revision on 2/11/21 documents R1 is at risk for falls. On 11/6/20 R1 was observed lying on the floor mat/pad. Interventions for 11/6/20 were utilize a high low electric bed with bolsters. On 2/11/21 R1 was observed lying on his side with his high backed wheel chair on top of him. His positioning device was not properly applied. His intervention for the fall of 2/11/21 was staff education provided on proper placement of the positioning device. R1's Positioning Device Care Plan documents ensure that R1 is positioned correctly with proper body alignment when wearing the positioning device. R1's Care Plan also documents that R1 has a diagnosis of Anoxic Brain Injury

R1's Fall Report dated 11/6/20 documents R1 was found on the floor lying on the pad near his bed. R1 was placed and remained on the floor to prevent further injuries. The report further stated no injuries were noted.

R1's Fall Report dated 2/11/21 documents R1 was on the floor of the room with the wheelchair on his side. The fall report further document the positioning device was not placed properly in the wheelchair. (R1's clinical record did not document a restraint assessment after this fall)

R1's OT (Occupational Therapy) therapist Progress and Discharge Summary dated 12/4/20 documents The R1 was seen for positioning recommendations to reduce the risk of falls and

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injury while providing a sensory stimulating and natural environment. The R1 was provided a high back reclining wheelchair seat cushion and a 4 point positioning system. front and rear anti tippers with leg rests removed and front anti tippers foam wrapped for skin protection. R1 is discharged from skilled physical therapy. His restlessness significantly declined, when sitting up in the wheelchair. Evaluation of neurological deficits and optimal positioning options for skin and joint protection, respiratory integrity and quality of life. Assessment and modification of high back wheel chair with wc (wheel chair) adaptations seating systems and positioning harness system. Care giver training to safely manage wheelchair positioning and seating system to his risk of falls and injury skin.

R1's Restraint- Physical (Initial Evaluation-Duplicate) dated 2/24/21, documents that alternatives did not work, prompting need for restraint: "Resident continues to climb out of bed or mattress on floor, maneuvering self across room." It further documents, "Devices are not a restraint, used for proper positioning." The date and time of first application is 11/30/2020 10:00. It also documents no physician order since it is not a restraint.

On 2/24/21, V1, Administrator, provided the product specifications which document, "Wheelchair Seat Belt Restraint Systems Chest Cross Medical Restraints Harness Chair Adjustable Strap." It also documents, "*Safety Wheelchair Seat Belt: Ergonomic Design, T shape of seat belt which restrain waist, abdomen and crotch, provide more comprehensive safety and stronger protection for elder or patient. *Multi-function: Our soft restraint belt have protective restraint and anti user falling down,

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toppling over and sliding forward. It can be used as wheelchair safety belt, wheelchair positioning belt, wheel chair seatbelt, medical restraints for wheelchair." It also documents, "Not intended to be used as a restraint!"

On 2/24/21 at 3:00 PM, R1 asleep seated in wheelchair with a device with a strap his chest and then straps to the chair. It also has a strap that goes between his legs and then straps underneath the chair.

On 2/25/21 at 12:00 PM, R1 seated in wheel chair with same device strapping him into the wheelchair.

On 02/25/21 at 02:11 PM, V26, Occupational Therapist, stated, "He (R1) uses that system (device strapping R1 into the wheelchair) to prevent falls and provide sensory stimulation. His diagnosis is anoxic brain injury"

On 2/26/20 at 8:20 AM, V20, Nurse Practitioner, stated, "That (device strapping R1 into the wheelchair) was initiated a month before his last hospitalization. It was used as a positioning device. worked on it the resident was in constant motion. It was used as a positioning device He could not tolerate being up in a geri chair or a wheel chair. He was receiving tube feeding, but we couldn't sit him up. We even called public health. We put it on him to improve his quality of life. Even with myself or staff standing by him, we still couldn't keep him in the chair. He would lean forward and come out of his geri chair. You couldn't redirect him. Now with the harness in place we are getting ready to set him up with a barium swallow."

" B "

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300.610a)
300.1210)b)
300.1210d)3)
300.1220b)2)

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

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S9999	Continued From page 11 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 nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3)Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.1220 Supervision of Nursing Services b)The DON shall supervise and oversee the nursing services of the facility, including: 2)Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. These requirements were not met evidenced by: A. Based on interview, record review, and observation, the facility failed to monitor, assess, and treat 1 of 3 residents (R1) reviewed for tube feedings in the sample of 54. This failure resulted in R1 losing 28 pounds in 3 months.	S9999		

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S9999	Continued From page 12 Finding Include: R1's Physcian Order Sheet (POS) dated 2/3/21 documents R1 has an enteral feed order of Jevity 1.5 bolus 240 milliliters every 4 hours via Gastrostomy Tube (G-tube). R1 Physician Order Sheet (POS) dated 2/4/21 documents R1's diet is Nothing by mouth (NPO). R1's POS dated 2/8/21 documents contact the dietician for consult related to hyponatremia and hyperkalemia. R1's POS dated 2/8/21 also documents Free water flush every 5 hours 90 ml per G-tube. R1's POS dated 2/12/21 documents nursing please obtain a weight on 2/12/21. R1's Clinical Record/ Electronic Health Record had no documentation that R1 was weighed on 2/12/21. R1's Clinical Record also had no documentation that he was weighed in the month of December 2020. R1's Nutrition Dietary Note, dated 12/21/20, documents R1's weight is 153 (from 11/18/20) R1's December weight is pending. R1 tested positive for COVID 19 on December 3, 2020. R1 receives Jevity 1.5 240 ML (milliliters) every 4 hours, and 90 ML of water every 4 hours. We will continue as ordered and monitor. R1's Nutrition Dietary Note, dated 1/25/21, documents recent hospital transfer 1/13-1/22 R1 weighed 140 on 1/14/21. R1's readmit weight is pending. R1 receives Jevity 1.5 240 ML every 4 hours. 90 ML of water every 4 hours. I will continue as ordered and monitor status.	S9999		

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S9999	Continued From page 13 R1's Nutrition Dietary Note, dated 2/4/21, documents Recent hospital transfer 1/28/21-2/2 his weight was 140. Readmit weight is pending. His hospital weight was 131. R1 receives Jevity 1.5 240 ML every 4 hours. 90 ML of water every 4 hours. I will continue as ordered and monitor status. I strongly recommend weekly weight monitoring. (R1's Clinical Record did not document a change in R1's enteral feeding until 2/25/21.) R1's Nutrition Dietary Note, dated 2/9/21, documents No new weight for review. (R1's) labs of 2/8/21 were reviewed Glucose high at 104, Sodium is low at 126. An order for Sodium Chloride 1 Gram Three times daily, and I concur with this step May need to consider a renal feeding such as Nephro to lower his potassium, but this also has lower sodium in the formulary. We will continue to monitor. R1's Nurses Note, dated 2/25/21, documents, R1's current weight is 125 pounds. Our last facility weight was 140 on 1/14/21. The physician and the dietician were notified. R1's Care Plan, dated 2/11/21, documents, (R1) receives tube feedings, and he will maintain adequate nutritional and hydration status. On 12/25/21 at 12:00 PM, V11, Licensed Practical Nurse (LPN), entered R1's room and told him it was time for him to eat. His feeding tube was accessed and placement was checked and also residual was checked with no issues. Jevity 1.5 one can was given through the G-tube along with g tube medications. R1 was swinging his legs and trying to grab at the water container. R1's stature was tall and thin.	S9999		

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	IL6010227	A. BUILDING: _____ B. WING _____	03/02/2021

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S9999	Continued From page 14 On 2/26/21 at 8:25 AM, V25, Dietician, stated, "I got notified last night about the most recent weight. I saw him twice last month. We put him on a continuous feeding of 70 ml per hour of Jevity last night. His hospital weight was 131. He is 125 now." 02/26/21 08:10 AM, V20, Nurse practitioner, stated, "Yes, I have been watching his weight. I felt as if there was a discrepancy, because he moved none stop. He was uncontrollable, even with staff standing next to him. He was also hospitalized due to his illness of COVID. He does not look as if he had a 30 pound weight loss. Speech therapy is seeing to get a barium swallow to see if he can now eat. That would boost his calories." On 2/26/21 at 9:55 AM, V4, Dietary Manager, stated, "I just took over the the weights again in January. They had other nurses doing the weights (the weight monitoring). When I took over, if they have a 5 lb weight loss, or gain we request a reweigh. They (the certified Nursing Assistants) then give back the weights, and I log them into the computer. We notify the dietician, I usually text her, and she will get back to me with ok, or a recommendation. I not sure what they were doing before January." On 2/26/21 at 10:35 AM, V2, Director of Nursing (DON), stated, "The restorative nurse (V24) was taking care of the weights, but she quit in November." The facility's Nutrition and Unplanned Weight Loss/Gain policy and procedure, dated 6/28/19, documents, all residents shall be weighed upon admission, monthly and as required by their clinical condition. Weekly weights should occur	S9999		

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for four weeks after admission, 4 weeks after a resident receives a G-tube, with a significant weight gain or loss, and finally whenever deemed necessary by the physician. Monthly weights should be obtained no later than the 7th of each month.

B. Based on observation, interview and record review, the facility failed to properly check placement and residual before administering a bolus tube feeding to one of 3 residents (R61) reviewed of tube feeding in the sample of 54.

Findings include:

On 2/25/21 at 11:29 AM, V12, LPN, washed her hands and donned gloves, and without checking for residual, instilled 50 mls of water into R61's gastrostomy tube (g-tube) while auscultating his abdomen. V12 stated she usually instills 50 to 100 mls into a g-tube to check the placement of the tube. V12 stated R61 has a history of pulling out his g-tube in the past.

R61's Electronic Medical Record (EMR) documents his diagnoses to include Cerebral Vascular Accident, Dysphagia, Other Artificial Openings of Gastrointestinal Tract Status, Hemiplegia and Hemiparesis.

R61's Physician Order dated 2/25/21 documents: Enteral Feed every 4 hours for Dysphagia Novasource Bolus 250 mls via gastrostomy tube (g-tube).

R61's Progress Note, dated 1/5/2021 at 8:24 PM, documents, "Nurse attempted to give pt (patient) feeding for 4:00 PM and nurse found g-tube lying next to pt in his bed. Nurse attempted to reinsert without success. Provider notified and requested

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to try and insert a foley. Foley inserted with 5 cc (cubic centimeters) saline in balloon. Some bleeding noted. Nurse asked pt if he pulled it out and pt stated "yes". Staff will continue to monitor for protective oversight.

R61's Progress Note, dated 1/31/2021 at 1:05 PM, documented, "Entered resident's room to perform treatment and do bolus feeding. Noted g-tube resting next to resident. Unable to state what happened with the tube. Attempted to reinsert x2 nurses with no success. (Physician) notified. New orders received to send to hospital."

R61's Minimum Data Set (MDS) dated 1/14/21 documents R61 is moderately cognitively impaired, totally dependent for eating, receives his nutrition via a feeding tube, and receives more than 51% of his calories and nutrition through his tube feeding.

R61's Care Plan, undated, documents, " (R61) is NPO, and requires tube feedings, related to chewing/swallowing difficulties, and at risk for aspiration. Receives Bolus feedings and flushes per G-tube. The interventions for this care plan include, "check for tube placement and gastric contents/residual volume per facility protocol and record."

On 2/25/21 at 11:53 AM, V2, DON, stated the nurse should check for residual and then check the placement of the g-tube by instilling an air bolus into the g-tube while using a stethoscope to auscultate the resident's abdomen. V2 stated "air should be used to check placement because you would not want to use water in case the g-tube is not in the right place".

The facility's Medication Administration via

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S9999	Continued From page 17 Enteral Tube policy and procedure, dated 1/22/19, documents, "Policy: All enteral medications will be administered in a safe, efficient and accurate manner to residents for whom they are prescribed and in accordance with current acceptable nursing practice." It continues, "19. Using a 50-60 cc (cubic centimeter) syringe check the placement of the enteral tube by auscultation of 10-30 cc air and through aspiration of stomach contents. " " B "	S9999		