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 11/23/2022

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 Investigation of Facility Reported Incident of 11/6/22/IL153548	S 000		
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 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 care and personal care shall be provided to each resident to meet the total nursing and 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 interview and record review, the facility failed to transfer R3 properly from wheelchair to bed, which requires the assistance of two staff for 1 of 3 residents, (R3) reviewed for accidents, in a sample of 3. This failure resulted in R3 sustaining an injury, requiring hospitalization and surgery. Findings include: R3's Face Sheet, undated documents, diagnoses include Displaced Intertrochanteric Fracture of Left Femur, Subsequent Encounter for Closed Fracture with Routine Healing Pathological Fracture, Left Femur, Sequel Personal History of (Healed) Traumatic Fracture, Displaced Intertrochanteric Fracture of Left Femur, Subsequent Encounter for Closed Fracture with	S9999		

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S9999	Continued From page 2 Routine Healing Pathological Fracture, Left Femur, Sequel Personal History of (Healed) Traumatic Fracture R3's Minimum Data Set (MDS), dated 10/29/22, documents R3 is moderately impaired for Cognitive Skills for Daily Decision-making and requires Extensive Assistance-2 persons assist in bed mobility, locomotion on unit and personal hygiene and Totally Dependent-2 persons assist for transfer, toileting and bathing. R3's Care plan 02/28/2022 documents, Care areas with interventions. R3 is at risk for falls related to impaired cognition with poor safety awareness, impaired mobility, incontinence of bowel and bladder, history of falls. R3 has history of attempting to transfer self from bed/chair. R3 is alert and oriented to self, mental function varies. Hears adequate, vision adequate with glasses, speech clear, sometimes understood and sometimes understands. Requires extensive to total assist with ADL'S and transfers via mechanical lift with 2 staff assist. R3's Unwitnessed Incident Investigation, dated 10/27/22 at 8:10 PM, documents that R3 was found in bed with bruising on and above the left knee and to the left inner thigh. It was believed that her knee/leg may be fractured. Director of Nursing and Assistant Director of Nursing assessed resident R3's injuries. The bruising on the outer aspects of the left knee is consistent with use of a mechanical lift pad. V2 (Director of Nursing/DON) stated, knee bruise had the appearance of shearing. The bruise on the upper part of the left leg is purplish-colored area goes around the thigh, not specific in shape, and does not appear to be an impact bruise.	S9999		

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S9999	Continued From page 3 R3's medical records from a local hospital, dated 10/27/22, documents R3 presented to the Emergency Department (ED), via Emergency Medical Services (EMS), from the nursing and rehab center with complaint of left lower leg (LLE), swelling with erythema. Per nursing home, when rounding on R3 this morning, the facility noted R3's left knee to be swollen related with redness and bruising. V4 at the nursing home reported to EMS that R3 had a previous fracture. R3's medical records from a local hospital dated, 10/29/22 documents, R3 presents to an area hospital from a local hospital following a fall. R3 was evaluated at ED for left knee bruising and swelling 2 days ago. Workups were negative. R3 was found down in the nursing home this AM. Workup showed a right intertrochanteric fracture. On arrival, secondary survey notable for left hip, left medial thigh and anterior shin bruise. Repeat imaging was obtained and confirmed minimally displaced left femoral intertrochanteric fracture in the setting of recent left distal femoral internal fixation. On 11/23/22 at 12:34 AM, V1 (Administrator) states, "I have no reason to think R3 injury was the result of a fall. R3 is immobile and does not get out of bed on her own. We sent R3 to another hospital because, we were not happy with the first hospital's care. It was difficult to determine, because of the pixel of the hall video/camera who was entering the resident's room. However, from the nursing station you get a better view, and you can see V12 (Certified Nursing Assistant/CNA) pushing R3 in the wheelchair. Later, you can see V12 leaving the room. V12 was terminated for dishonesty in the investigation. On 11/23/22 at 10:13 AM, V3 (Assistant Director	S9999		

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S9999	Continued From page 4 of Nursing/ADON) states, "V12 was the CNA assigned to R3 for that shift. V12 (CNA) had only been here for one month but was not responding to the training. I provided extra training for him, but V12 was not providing the type of care we would prefer for our residents. V12 was actually terminated for improper transfer and poor peri-care. On 11/23/22 at 10:30 AM, V4 (Licensed Practical Nurse/LPN) states, R3 was re-admitted to facility 11/3-did not have any new orders. States, he, (V4), was R3's nurse the day before the incident. The skin assessment did not document any bruising and did not have any facial grimacing or calling out in pain. Hospital reports R3 did have actual fracture. R3 did not experience a fall. Uncertain as to where the hospital got that information." On 11/23/22 at 10:09 AM, V5 (Certified Nursing Assistant/CNA) states, "I was providing care to R3 and noticed a bruise on the front of her thigh. It was not there the day before. I reported it to the nurse. I had only been on the job for 3 days and received a write up, because I did not report it in a timely manner. I noticed it earlier that day but did tell the nurse until later. It was my first day, I am uncertain of the time frame. I was interviewed regarding the bruise/incident. I do not think R3 fell. When I started work here, we were provided training on how to use the (mechanical) lift. It always takes at least 2 to operate the mechanical lift. From the write up, I had to attend training again on how to report abuse and how to operate the mechanical lift." On 11/23/22 at 12:45 PM, V8 (Regional Clinical Director of Operations) states, "R3 did not have any reports of falls. We were concerned that the	S9999		

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S9999	Continued From page 5 hospital did not take X-rays of her leg and sent her to another hospital. I cannot say V12 (CNA) dropped R3 or let R3 fall. I can say he did not follow the policy for transferring." On 11/23/22 at 12:55 PM, V9 (Nurse Practitioner/NP) states, "R3's age, morbidity and previous history of fractures makes R3 a prime candidate for injury. I cannot say R3's fracture could or could not have been avoided." On 11/23/22 at 11:13 AM, V10 (Certified Nursing Assistant/CNA) states, "I was the nurse on another Hall B and was called over to assess the resident. I was called over to assess R3 by the nurse because, the resident leg looked funny-(was turned inward). Upon assessment I saw the bruise, contacted the doctor and R3 was sent out for an evaluation to a local hospital. I did speak with a CNA and she stated that V12 (CNA) did doubles on the Hall. I have worked with V12 because, V12 floated. Did not know V12 to harm a resident and had not heard of any complaints about V12 from the other workers. Unaware if V12 brought R3 from the dining room to her room." On 11/23/22 at 11:50 AM, V11 (Certified Nursing Assistant/CNA) states that she (V11) worked Tuesday and Wednesday and there were no bruises. The day when a bruise was noticed, the nurse was notified. I have no idea how she got the bruise. The mechanical lift always, always requires 2 people. The regular staff do help in training new staff because we are operating as a team. I did not see V12 (CNA). R3 was sent out to the ER that Thursday and returned the same day. The next thing I know R3 was being sent out again. R3 is confused, is in and out and forgets a lot. R3 can make her needs known.	S9999		

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S9999	Continued From page 6 Unfortunately, R3 cannot tell what happened. I have not known V12 to harm any residents. On 11/23/22 at 11:30 AM, V12 (CNA) states, "I did a walk around at the beginning of my shift. I came in at 2:00 PM and at 2:30 PM the injury to R3 was noted. I worked at that facility as a CNA through agency and came on board as regular staff. I don't see how they could blame me, and her leg has been fractured before. In the past I looked at her foot and it was red. I reported that to the nurse, and R3 was sent to the ER. I know that to use a mechanical lift it takes 2 people. I have been a CNA for 23 years and have worked all over this country. I was suspended pending the investigation. The next day I got a call from the administrator that I was "not a good fit." On that Hall, you can be assigned residents. But they do not take into consideration the acuity of the residents." On 11/23/22 at 2:30 PM, V14 (Certified Nursing Assistant/CNA) stated that R3 transfers with a mechanical lift with 2 people. Facility did not produce the facility policy and procedures on Incidents/Accidents. (A)	S9999		