

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6010227</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/02/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CASEYVILLE NURSING &amp; REHAB CTR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>601 WEST LINCOLN AVENUE CASEYVILLE, IL 62232</b>
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S 000	Initial Comments  Complaint Investigations:  2348628/IL165573	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.  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	

Illinois Department of Public Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S9999	<p>Continued From page 1</p> <p>care needs of the resident.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>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:</p> <p>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.</p> <p>These requirements were not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to position R2 in bed, in a safe position to prevent a fall in 1 of 1 resident (R2) in the sample of 3. R2 was sent to Emergency Room with a detection of acute cerebral ischemia and a small left frontal scalp hematoma.</p> <p>Findings Include:</p> <p>R2's Face Sheet documents an admission date of 1/14/2021. Diagnosis' include Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Non-Dominant Side. Cerebral Infarction due to Unspecified Occlusion or Stenosis of Right Middle Cerebral Artery. Aphasia, Dysphasia.</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>R2's Minimum Data Set, MDS, dated 9/25/2023 documents, R2 is severely cognitively impaired and is totally dependent on staff for bed mobility and transfers. R2's MDS dated 9/25/2023 documents, R2 has had no falls since admission.</p> <p>R2's care plan updated 6/12/2023 documents, R2 is at risk for falls related to diagnosis of Dementia, Cerebral Vascular Accident, Hemiplegia, Hemiparesis, Muscle Weakness, Lack of Coordination. Transfers requires mechanical lift and 2 assist. Total care for all Activities of Daily Living, ADLs. Interventions include Notify Physician as condition warrants. Remind R2 not to attempt transfers alone.</p> <p>R2's fall risk assessment dated 9/26/2023 documents, R2 is at low risk for falls.</p> <p>R2's side rail assessment dated 9/26/2023 documents, bed rails are not indicated at this time. The Interdisciplinary Team, IDT, has reviewed the R2's capabilities, needs, and preferences in relation to bed rail use and has determined: No bed rail indicated.</p> <p>R2's Progress Notes dated, 10/14/2023 at 11:50 PM document, "(R2) was found on floor face down after this Nurse heard a loud thump. (R2) turned on back and noted bleeding coming from (R2's) nose and a moderate pile of blood on floor. This Nurse immediately responded with assistance of another Nurse and Certified Nursing Assistant, CNA, to get (R2) off floor and back in bed. Mechanical lift used to safely transfer resident back in bed, vital signs assessed. Vital Signs within normal limits. Physical assessment performed. Breathing unlabored, and even. Radial and pedal pulses</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>palpable, bowel sounds present, and active in all quadrants. Right hand grip strong. Left upper and lower body flaccid. Gastronomy-tube patent, flushes easily with no residual noted. Gastronomy-tube disconnected during transfer back to bed. Incontinence care provided, by Certified Nursing Assistant, CNA. Tube feed restarted after peri care performed. (R2) denies pain or discomfort. Open abrasion to right side of nose with blister formation noted. Scratches to left cheek and bridge of nose. Redness and bruising noted to nose. No other injuries or skin breakdown noted. Will continue to monitor, all parties notified".</p> <p>R2's Progress Notes dated, 10/15/2023 at 7:14AM documents, R2 returned from hospital with no new orders. R2 is not complaining of pain, R2 does have any serious injuries, R2 does have some bruising on both eyes and abrasions to her right cheek. Will continue to monitor.</p> <p>R2's ER records dated, 10/15/2023 document: No acute intracranial abnormality. Magnetic Resonance Imaging, MRI is more sensitive for the detection of acute cerebral ischemia. Small left frontal scalp hematoma without underlying skull fracture. No acute fracture of the maxillofacial bones. Multilevel degenerative disc disease without acute fracture of the cervical spine. If there is clinical concern for acute spinal cord or ligamentous injury.</p> <p>R2's fall investigation dated, 10/17/2023 documents, on this occasion R2 was observed face down on the floor after the Nurse heard a loud thump coming from R2's room. The Nurse assessed for injury and noted that there was a moderate amount of blood coming from R2's nose. There were minor scratches to R2's left</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>cheek and bridge of nose. Blood pressure was elevated, but all other vitals were within normal limits. No other injuries were noted at the assessment. Breathing was unlabored and bowel sounds were present. G-tube still in the correct placement. R2 was returned safely in bed via mechanical lift by 2 Nurses and CNA. CNA performed peri care and Nurse restarted tube feed. R2 was sent to Emergency Room for further assessment. All parties notified. Based on interviews and review of R2's chart, R2 needs to always have a wedge in place to help prevent future falls. I educated staff on making sure R2 is positioned properly in bed and that the wedge needs to be always on R2's right side while changing positions to help prevent wounds.</p> <p>On 10/31/2023 at 2:45PM V3, Assistant Director of Nursing, ADON, stated, she is not sure what happened with R2 falling out of bed. V3 stated, "We interviewed all the staff that were working that night and there was nothing unusual about the night. (R2) can swing herself a little. She must have been put to bed a little too close to the edge".</p> <p>On 10/20/2023 at 12:35PM V4 and V7, CNAs, transferred R2 from chair to bed via mechanical lift, with no issues. R2 observed to move her right hand and arm slightly. R2 has low air loss mattress. No side rails up. No wedge in place.</p> <p>On 10/31/2023 at 1:45PM R2 observed in bed with no wedge in place or side rails up.</p> <p>On 10/20/2023 @11:00AM V6, CNA, stated, "(R2) is able to use one side. Not very many people know that about (R2). I think she needs a different bed. I wasn't here when she fell, but I heard about it".</p>	S9999		

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S9999	Continued From page 5  On 10/31/2023 at 1:10 PM V12, CNA, stated, "I was not at work the night (R2) fell out of bed, but I heard about it. (R2) can move her top half. People think she is flaccid, but she isn't. I have removed her wedge before, and she rolled. I can see how she could roll out of bed".  On 10/31/2023 at 2:55PM V11, CNA, stated, "I was not working when (R2) fell out of bed. I don't think she moves at all. She uses a wedge, so we put her side-back-side".  Fall policy updated 2/20/2023 states, all incident 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 and or Administrator. (B)	S9999		