PRINTED: 01/22/2024 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING IL6010227 11/16/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **601 WEST LINCOLN AVENUE** CASEYVILLE NURSING & REHAB CTR CASEYVILLE, IL 62232 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XS) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S 000 \$ 000 Initial Comments COMPLAINT INVESTIGATION 2349391/IL166559 S9999 Final Observations S9999 Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)2) Section 300.610 Resident Care Policies 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 property supervised nursing

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

care and personal care shall be provided to each

resident to meet the total nursing and personal

care needs of the resident.

TITLE

Attachment A

Statement of Licensure Violations

(X6) DATE

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PRINTED: 01/22/2024 **FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING IL6010227 11/16/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **601 WEST LINCOLN AVENUE CASEYVILLE NURSING & REHAB CTR** CASEYVILLE, IL 62232 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (XS) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) S9999 Continued From page 1 S9999 Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. Pursuant to subsection (a), general d) nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour. seven-day-a-week basis: All treatments and procedures shall be administered as ordered by the physician. These requirements were not met as evidenced Based on observation, interview and record review the facility failed to perform and monitor proper catheter care and monitor a penile wound for 1 of 3 (R3) residents reviewed for catheter care in a sample of 3. This failure resulted in R3 having a preventable penile injury resulting in a surgical intervention. Findings include: R3's Care Plan, dated 3/11/22, documents R3 is at risk for skin breakdown and/or pressure ulcer formation d/t (due to) dx (diagnosis) hemiplegia, anemia, multiple sclerosis, muscle weakness, contractures, Vit D deficiency et (and) DMII

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(Diabetes). R3 is total care for ADL's (activities of daily living). Incont (incontinent) of bowel. Has foley catheter. Currently has reddened area to penis - (Barrier) q (every) shift. No open areas noted. Apply (barrier) protect to reddened area on penis as ordered. Skin checks weekly. 3/16/22 documents (R3) has indwelling 16FR foley catheter r/t (related to) dx neurogenic bladder.

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		2) MULTIPLE CONSTRUCTION BUILDING:		(X3) DATE SURVEY COMPLETED	
IL6010227		B. WING		C 11/16/2023			
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, 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)		(XS) COMPLETE DATE	
S9999	Continued From page 2		59999				
	(R3) has: Condom// Suprapubic) Cathet (R3's) catheter bag the bladder and awa CATHETER: Chang (physician) orders, s sheet/MAR. Empty prn (as needed). Mo pain/discomfort due Monitor/record/repo burning, blood-tinge output, deepening of increased temp, Uri	to catheter. It to MD for s/sx UTI: pain, It to MD for s/sx UTI: pain, It urine, cloudiness, no If urine color, increased pulse, Inary frequency, foul smelling Ittered mental status, change					
	External Ointment (Neomycin-Bacitrac topically one time a cleanse with wound	er Sheet, not dated, 23 Neosporin Original in-Polymyxin). Apply to penis day for tear to meatus cleanser apply Neosporin e open to air. Discontinued			Э		
		Ith Record was reviewed and f assessment and monitoring was found.					
	April 2023 to June 1 catheter care. Cathe 6/15/2023. No furthe care in June. July T/Catheter Care Daily day shift. August T/8/4/2023. Septembe 9/4, 9/13, 9/18, 9/25	ninistration Record (TAR) from 6, 2023 documents daily eter care discontinued er documentation of catheter AR documents 7/7/2023 and PRN (as needed) every AR documents blanks on er TAR documents blanks 9/1, 6, October TAR documents 0/23, 10/24, 10/28, 10/30.					

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE SURVEY COMPLETED		
				c			
		IL6010227	B. WING		11/16/202:	3	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
CASEYVILLE NURSING & REHAB CTR 601 WEST LINCOLN AVENUE CASEYVILLE, IL 62232							
(X4) ID				ID PROVIDER'S PLAN OF CORRECTION			
PRÉFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(5) PLETE ATE	
S9999	Continued From page 3		S9999			·	
	R3's Urology Report, dated 8/7/2023, documents R3 has latrogenic Hypospadias has developed at the base of the penis.						
	on back. V4, Certific completed peri care	ed Nursing Assistant (CNA), e. V4 opened the incontinent in R3's penis from the tip to					
	the base of the pen	is.					
	Nurse (LPN), stated stated R3 received	20 PM V5, Licensed Practical I she takes care of R3. V5 a new super public catheter.					
	was in the penis. V5 catheter, it was diffic	roblems when the catheter stated when changing the cult to replace and R3 would			:		
	causing a slit to R3'	s. V5 stated the tubing was s penis. V5 stated they h Bactroban and open to air					
	when it was time to	out a dressing on it. V5 stated change the catheter, they here was a lot of bleeding. V5					
	stated R3 was sent to be changed. V5 s	to the hospital for the catheter stated after R3 returned from were received for the facility to	=				
	not change the cath urologist. V5 stated	eter and have changed at a they sent R3 to the a (local)					
	due to possible com	the catheter was not changed plications. V5 stated R3 was ts and suprapubic catheter					
		d R3 received the suprapubic	:				
	she has worked at t	2:40 PM, V4 (CNA), stated he facility for a few months.					
t.	R3's penis has beer	aken care of R3. V4 stated way since she started 3. V4 stated R3 is a large					
		g R3 the catheter pulls and					

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the penis.

chart. V11 stated a catheter change on 12/25/23 was documented but nothing about a wound to

On 11/15/2023 at approximately 3:20 PM, V2 (Director of Nursing), stated she was new to the facility about 2 months ago. V2 stated she was

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE SURVEY COMPLETED	
		IL6010227	B. WING		11/1	6/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1		
CASEYV	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	
S9999	PROVIDER OR SUPPLIER  STREET ADD  601 WEST  CASEYVIL  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		S9999				
	Urinary Catheter Ma	aintenance: 1. Catheter care:					

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FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ C B. WING IL6010227 11/16/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **601 WEST LINCOLN AVENUE CASEYVILLE NURSING & REHAB CTR** CASEYVILLE, IL 62232 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (XS) COMPLETE DATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) S9999 Continued From page 6 S9999 Performed daily by nursing staff, and is part of routine perineal care, performed after each bowel incontinence, and/or as needed if secretions build around the urinary meatus after. (B)

STATE FORM

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