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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) COMPLETION DATE
F 501	Continued From page 19 nurses are afraid of him as he yells at them and "is not nice". Z1, Medical Director, was interviewed by telephone on 7/30/12 at 11:35 AM. Z1 stated that the Facility "should have tried harder to get in touch with Z2. They (the Facility) has my home phone number. They should call the hospital. They need to try harder and if they can't get in touch with a physician, they should call me. They could have called 911 - I would have expected that".	F 501		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.610c)2) 300.1030a)3) 300.1030c) 300.1210d)1)2)3) 300.1630a)2) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by	F9999		

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F9999	Continued From page 20 written, signed and dated minutes of such a meeting c) These written policies shall include, at a minimum the following provisions: 2) Resident care services including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services, dietary services, social services, clinical records, dental services, and diagnostic service (including laboratory and x-ray). Section 300.1030 Medical Emergencies a) The advisory physician or medical advisory committee shall develop policies and procedures to be followed during the various medical emergencies that may occur from time to time in long-term care facilities. These medical emergencies include, but are not limited to, such things as: 3) Traumatic injuries (for example, fractures, burns, and lacerations). c) There shall be at least one staff person on duty at all times who has been properly trained to handle the medical emergencies in subsection (a) of this Section. This staff person may also be conducted in fulfilling the requirement of subsection (d) of this Section, if the staff person meets the specified certification requirements. Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following	F9999		

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F9999	Continued From page 21 and shall be practiced on a 24-hour, seven-day-a-week basis: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. 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 300.1630 Administration of Medication a) All medications shall be administered only by personnel who are licensed to administer medications, in accordance with their respective licensing requirements. Licensed practical nurses shall have successfully completed a course in pharmacology or have at least one year's full-time supervised experience in administering medications in a health care setting if their duties include administering medications to residents. 2) Each dose administered shall be properly recorded in the clinical record by the person who administered the dose. 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 REQUIREMENTS WERE NOT MET AS EVIDENCED BY: Based on record review and interview, the Facility	F9999		

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failed to provide effective pain management and timely emergency medical services for 1 of 2 residents (R2), reviewed for falls in the sample of 7. This failure resulted in a delay in treatment for R2 who experienced a fracture of the right intertrochanteric.

Findings include:

The Facility nurses notes for R2 document, "6/14/12, 9:50 PM, reported to this nurse by staff that report was needed. R2 was found on the floor of her room at 9:30 PM by a CNA, by the white shelves in her room. R2 had unbuckled her seat belt of the wheelchair and tried to stand up. Abrasion to right temple area in hairline and right wrist. E2, Director of Nursing, was notified at this time.

10:15 PM, Power of Attorney (POA) was notified of the incident. Told us to call him if anything changed.

10:30 PM, R2 resting quietly at this time. Call light in reach. Bed alarm activated.
6/15/12, 9:50 AM, This nurse called and informed physician of R2 complaining of hip pain. Telephone order received to x-ray right hip and monitor for changed and notify physician.

10:15 AM, POA notified of complaints of pain and new order. He stated "let me know what it says".

1:30 AM, x-ray technician arrived.

4:00 PM, family arrived and wanted R2 sent out to the emergency room due to no report yet and she is hurting even after pain medication has

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F9999	Continued From page 23 been given. Physician notified of this and received order to send R2 to emergency room for evaluation. 4:30 PM, R2 left facility via ambulance. 4:40 PM, x-ray report received. X-ray report sent to physician. 10:45 PM, (late entry) for 3:45 AM, R2 complaining of pain in her right hip and leg. Called E2 and she said to call R2's physician. Called his home once and paged him twice. No response. Had staff leave R2 in bed. Passed on in report that still waiting for Dr's response". E3, LPN, is the nurse who initially assessed R2 after her fall. E3 was interviewed concerning the incident on 7/16/12 at 2:10 PM. E3 said that she was working on the back hall that evening and another LPN, E5, was working on the front hall. E3 said that the two CNA's working on the front hall came to her and told her that R2 had fallen. The two CNA's said that they reported it to E5 but, it was her last night working in the Facility and did not want to be bothered with any paper work. E5 reportedly told the CNA's "It never happened and I'm not filling out a report". E3 said "I went and assessed R2 and did the incident report. I had the girls put her in bed. Her legs were equal and she had no complaints of pain. R2 just wanted to go back to sleep. She was not in any pain. She was not grimacing or showing any other non-verbal signs of pain. I kept trying to call her Dr but, could not get an answer anywhere. I even called the hospital and had them page him. I forgot to document all of the attempts I made to get ahold of him. It was close	F9999		

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F9999	Continued From page 24 to shift change". E4 was the nurse who came on the night shift on 6/14-15/12 and relieved both E3 and E5. During an interview with E4 on 6/16/12, at 2:22 PM, it was stated that E3 caught her by the time clock and told her about R2 falling and E5 not filling out an incident report. E4 said that she told E3 to call the DON. E3 did that immediately. E2 told E3 to call the hospital and have the Dr. paged. E3 had the Dr paged however, got no response. E4 said that she continued to check on R2 and R2 slept until about 3:00 AM. E4 said that when the CNA's attempted to turn R2, R2 began screaming out in pain. E4 said that she told the CNA's to leave R2 in bed and attempted to once again call R2's physician. E4 still got no response. E4 said "It did not dawn on me to call the Medical Director or 911. I called E2 again and she said to keep trying to get ahold of him. I still hadn't gotten ahold of him when day shift came on duty". During a telephone interview with Z3, R2's power of attorney, on 7/17/12 at 9:50 AM, it was stated that when he arrived at the Facility on 6/15/12 at 4:00 PM, R2 was moaning in bed and thrashing about. Z3 said that R2's condition was very upsetting - "she was in terrible pain". Z3 said that he demanded R2 be sent to the emergency room immediately. R2 was originally admitted to the Facility from an assisted living facility on 1/14/12, with diagnoses, in part of Dementia, Parkinson's and fractured right femur. R2's physician order's documents an order dated 12/1/11 for "Hydrocodone with Aspirin, 5/500, take one tablet by mouth every 4 hours as needed". A review of R2's Medication	F9999		

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F9999	Continued From page 25 Administration Record (MAR) documents that R2 did not receive any Hydrocodone on 6/14 or 6/15/12. On 7/19/12, at 2:20 PM, E2 presented documentation that 2 Hydrocodone tablets were signed out on R2's "Shift Count Narcotics Record". The "Shift Count Narcotics Record" documents that on 6/15/12 at 6:00 AM, R2 had 28 Hydrocodone tablets. On 6/15/12, at 10:00 PM, R2 had 26 Hydrocodone tablets remaining. There is no documentation in R2's clinical record that the Facility assessed R2's pain level prior to and after administering Hydrocodone tablets on 6/15/12. R2's "Pain Assessment", dated 4/11/12, documents that R2 had "No Pain Indicators Present - verbal and/or non-verbal". E7, LPN, was the nurse working with R2 during the day shift on 6/15/12. During an interview with E7 on 7/19/12 at 11:20 AM, it was stated that E7 did give R2 two doses of Hydrocodone during the day shift. E7 said that it was "really busy that day. I gave R2 a dose before noon and before she went out. I forgot to sign it off. R2's family came to me and said that she was acting like she was hurting bad. When I saw her, R2 was slightly grimacing but, not acting like she was in a lot of pain - she wasn't crying out. The Hydrocodone did help some - I forgot to chart that also - the grimacing was lessened and her family said that it seemed like it relieved her pain". During an interview with E2 on 7/16/12, at 1:15 PM, it was stated that they are not used to being unable to contact a resident's physician and the nurses did not think about calling 911 to send R2 out to the emergency room or to contact the Medical Director.	F9999		

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The Facility policy entitled "Guidelines for Physician Notification of Resident Change in Condition" documents "Falls - hip pain with palpation of inability to walk - immediate notification". The policy does not address what facility staff are to do when unable to contact a resident's physician. E2 confirmed during the interview on 7/16/12 at 1:15 PM that the Facility does not have a policy regarding inability to contact a resident's physician.

R2's hospital history and physical documents that she was admitted to the hospital on 6/15/12 for a displaced right intertrochanteric hip fracture. R2 "was cleared for surgery and an open reduction, internal fixation of the right hip fracture" was performed.

Z1, Medical Director, was interviewed by telephone on 7/30/12 at 11:35 AM. Z1 stated that the Facility "should have tried harder to get in touch with Z2. They (the Facility) has my home phone number. They should call the hospital. They need to try harder and if they can't get in touch with a physician, they should call me. They could have called 911 - I would have expected that".

Z2, R2's physician, was interviewed by telephone on 7/30/12 at 1:00 PM. Z2 stated "I was not aware of them (the Facility) trying to call me. The local hospital is my answering service - after 5:30 PM, our phones get answered at the hospital switchboard. The hospital operator then pages or calls me. Plus, my home phone number is in the phone book. I didn't get the message about R2 until 9:47 AM on 6/15/12. There was no great urgency in the message, that's why I ordered a

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mobile x-ray. They didn't assess her well and relay that information to me. They should have sent her out 911 if they couldn't get ahold of me. It should have been automatic".

B

300.1210b)5)
300.1210d)6)
300.3240a)

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 care needs of the resident. Restorative measures shall include, at a minimum, the following procedures

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.

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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 REQUIREMENTS WERE NOT MET AS EVIDENCED BY:

Based on record review and interview, the Facility failed to identify individual resident risk; implement effective interventions and monitor those interventions, for 1 of 3 residents (R2) reviewed for falls in the sample of 7. This failure resulted in R2 sustaining an intertrochanteric fracture.

Findings include:

A review of R2's clinical records document that she was originally admitted to the Facility on 1/14/12, with diagnoses, in part, of Fracture of Femur, Parkinson's Disease and Dementia.

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R2's Minimum Data Set (MDS), dated 4/11/12, documents that R2 is cognitively impaired; required the limited physical assistance of one staff member for transfers, walking and activities of daily living; and was not steady while moving from a seated to standing position, walking or surface-to-surface transferring.

R2's care plan, with a beginning date of 1/23/12, documents a "Problem" of "FALLS: Resident has risk factors that require monitoring and intervention to reduce potential for self injury. Risk factors include confusion, impaired cognition, unaware of safety, needs extensive assistance of 1 with activities of daily living, impaired balance, requires assist to stand, tremors, history of falls, left hip replacement, weakness, gets up without assist and should not, laxative and psychotropic use".

The Care Plan "Goal" for this "Problem" documents "Resident will follow safety suggestions and limitations with supervision and verbal reminders for better control of risk factors".

The Care Plan "Approaches" for this "Goal" include "Observe for non-verbal signs of restlessness that may precipitate movement and attempts to stand/walk unattended; self releasing belt applied to wheelchair, to wear when in wheelchair and she is able to release it herself".

The plan of care does not address what staff is supposed to do if R2 is showing signs of restlessness. There is no assessment for the use of the self-releasing seat belt in R2's clinical record. R2's "Fall Risk Assessment", dated 4/11/12, documents that R2 was at "High Risk"

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F9999	Continued From page 30 for falls. During an interview with E6, Licensed Practical Nurse (LPN) and Care Plan/MDS Coordinator, she stated that the Facility applied an alarmed self-releasing seat belt to R2's wheelchair on 1/17/12. E6 confirmed that the Facility failed to assess R2 for the use of the seat belt. E6 stated that "in the beginning" R2 was able to comprehend that the belt served as a reminder to her not to ambulate independently. E6 said that she believes that R2's mental status had been declining prior to her fall on 6/14/12. E6 also confirmed that the Facility failed to care plan for interventions when R2 would become restless or "fidgety". R2 does not have a physicians order for the use of the alarmed self-releasing seat belt. The facility incident investigation reporting forms document that R2 had falls in the Facility on 1/16/12, 1/19/12,2/18/12 and 6/14/2. The investigation for the 1/16/12 fall documents that at 5:00 AM, "R2 was seated in living room watching television. (R2) told staff that the show was over and she was getting up to change the channel and fell". The corrective action for this fall is "will make sure that she has a remote for her TV No injuries were noted. PT/OT to evaluate and treat". Physical Therapy Discharge Summary, dated 1/16 - 3/3/12, documents that physical therapy was providing strengthening exercises to R2's lower extremities "to increase hip and knee strength". R2 was discharged from physical therapy on 3/3/12 as she had "met her maximum potential". On 1/19/12, at 4:00 PM, the investigation	F9999		

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documents that R2 was "transferring from bed to get water". The form states that a bed alarm was present however, it does not state if the bed alarm was sounding. The corrective action for this fall is "resident is confused, has dementia, make sure water and belongings are close to resident's chair or bed so resident can reach them". No injuries were noted.

On 2/18/12, at 2:45 PM, the investigation form documents that R2 had been sitting in her recliner and "fell going to the bathroom" at 2:45 PM. R2 sustained a skin tear (no size given) to her left elbow. The corrective action for this fall is "resident up by herself to go to the bathroom, spoke with resident's family and asked if we could move her closer to the nurses station for increased observation". The investigation does not document if the alarmed self releasing seat belt was on the chair or if it was sounding.

The Facility "Final Investigation Report" documents that "On June 14, 2012, Certified Nurses Aide (CNA) responded to alarm sounding and noted R2 on the floor by her wheelchair. CNA attempted to put resident to bed around 8:30 PM, R2 refused, as CNA was working she would do a visual check on R2 due to resident being fidgety. The CNA stated that she hear R2's alarm going off. When she entered the room the CNA saw R2 on the floor by her wheelchair with her self releasing belt disengaged. E3, Licensed Practical Nurse (LPN), was notified of the incident and assessed R2, who had no obvious injuries at the time. R2 began showing signs of pain during the early morning of 6/15/12. R2's physician was notified and an x-ray was ordered. At 1:30 PM, mobile x-ray company arrived and x-ray was

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taken. At 4:30 R2 was sent to the hospital. Final x-ray results arrived at Facility at 4:45 PM showing an intertrochanteric fracture".

The investigation for the fall which occurred on 6/14/12 documents that at 9:30 PM, R2 experienced a fall from her wheelchair. R2 sustained an abrasion to her right temple and right wrist, and a right intertochanteric fracture. The investigation documents that R2 was sitting in her wheelchair in her room at the time of the fall. The seat belt was on the wheelchair. The investigation does not state if the seat belt was released and/or sounding.

E10, CNA, was interviewed by telephone on 8/1/12 at 10:55 AM. E10 said that she was the CNA assigned to R2 the evening of 6/14/12. E10 said that she had worked with R2 since R2's admission to the Facility on 1/14/12. R2 said that she was very familiar with R2. E10 said that throughout the evening of 6/14/12, R2 had been crying and was agitated. E10 said that R2 was very agitated during supper, "she kept fidgeting with her seat belt, she would mess with it until she got it open - shaking and squeezing on the buckle. I pushed her back to her room after supper and asked her if she wanted to watch television or sit in her recliner. She was crying the whole time. She said that she just wanted to sit there. "I didn't lock her wheelchair wheels so that she could scoot around if she wanted to. She cried a lot and fidgeted all of the time". E10 said that she left R2 sitting in her wheelchair in her room where she could be visualized whenever E10 walked by the door to R2's room. "I put R2 in her room at about 6:15-6:30. Every time I went by her room I looked in on her. I

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146117	A. BUILDING ______ B. WING ______	C 07/31/2012

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) COMPLETION DATE
F9999	Continued From page 33 heard her seat belt alarm going off about the time I was doing bed checks. I went in and found her lying on the floor on the other side of her wheelchair". E10 said that R2 is restless "a lot". E10 said that R2's family liked her to wear dresses and she would pick at the hem of her dress or lean over and fiddle with her wheelchair. E10 said "R2 was always keeping her fingers busy". E10 said that R2 would have moments of lucidity but, was confused most of the time. E10 said that she learned how to work with R2 from experience. E10 said that she found that when R2 got restless, R2 liked sitting in her recliner, eating candy or watching television. E10 said that she never read anything in R2's plan of care what to do when R2 became restless. B	F9999		