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 _____	02/05/2015

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 000	INITIAL COMMENTS Annual Licensure and Certification Survey An Extended Survey was conducted.	F 000		
F 161 SS=E	Licensure Survey for Subpart S: SMI 483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to maintain a surety bond in an amount sufficient to protect resident trust funds. This failure has the potential to effect 12 sampled residents (R1, R5, R6, R8, R9, and R13 through R19) and 37 residents on the supplemental sample (R3, R10, R11, R12, and R20 through R52). The facility's "Long-Term Care Facility-- Resident Surety Bond" documents the amount of the current bond is $60,000.00. The facility's "Resident Trust Account" bank statement dated October 31, 2014 documents a balance on 10/1/14 of $64,339.23. On 2/3/15 at 1:50 PM E10, Business Office Manager, stated, "(E1 Administrator) made a deposit in error and that is what put the account over the bond."	F 161		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 161	Continued From page 1 On 2/3/15 at 1:55 PM E1 stated, "I made that deposit at the direction of corporate." The facility's list of "Resident Trust Account Balance" dated 2/1/15 documents 49 residents for whom the facility manages funds (R1, R3, R5, R6, and R8 through R52).	F 161		
F 225 SS=F	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225		

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F 225	Continued From page 2 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to report an allegation of verbal/mental abuse immediately to the administrator, failed to thoroughly investigate an allegation of abuse, failed to protect residents from potential further abuse, and failed to report to the State Survey and Certification agency. These failures have the potential to effect all 55 residents residing in the facility. Findings include: The Resident Council Minutes dated 1/22/15 document, "There was one complaint that a nurse (E5, Certified Nurse's Assistant) is yelling and being rude to resident." The Resident Council Department Response dated 1/22/15 documents, "There was one complaint that (E5) is loud and being rude to resident." On 2/03/15 at 12:00 PM, E4 (Activity Director) stated that during the resident council meeting on 1/22/15 R17 alleged that a nurse (E5) was yelling and being rude to her. E4 stated that she did not go immediately to E1 (Administrator) and report	F 225		

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F 225	Continued From page 3	F 225		

the allegation. E4 stated that after the meeting she spoke to R17 about the allegation and at that time R17 told her that E5 was being loud and rude to her. E4 stated that she rewrote the resident council minutes to say, "There was one complaint that a nurse (E5) is loud and being rude to resident." E4 stated that after speaking to R17 she completed the Resident Council Department Response form. E4 stated that she went to E1's office to speak to her but E1 was in a meeting and did not want to interrupt. E4 stated that she then went to E2 (Director of Nursing) and reported the allegation.

On 2/03/15 at 12:35 PM, E2 stated that E4 brought her the Resident Council Department Response form (on 1/22/15). E2 stated that E3 (Assistant Director of Nursing) heard her and E4 discussing situation and that E3 then stated that she had already taken care of the issue several weeks ago. E2 stated that she did not talk to R17 that day about the allegation. E2 stated that E4 did not tell her that R17 alleged a E5 was yelling and being rude. E2 stated that if E4 would have told her that R17 alleged E5 was yelling and being rude that she would have investigated it differently. E2 stated that she did not document her investigation. E2 confirmed that E5 works with all residents in the facility. E2 confirmed that E5 has never been suspended pending an investigation.

On 2/04/15 at 11:30 PM, E1 stated that she became aware of the 1/22/15 Resident Council Meeting Report the next day. E1 stated that she was unaware that the Resident Council Meeting Report documented that "There is one complaint of a nurse yelling and being rude." until 2/03/15 but E1 stated she was aware that E4 had

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F 225	Continued From page 4 changed the Resident Council Meeting Report. E1 stated the facility policy states that the administrator should have been notified. E1 stated that E4 should have reported the allegation of verbal/mental abuse to her immediately. The Abuse Prevention Program Facility Policy dated 11/11/11 documents "Employees are required to immediately report any occurrences of potential/alleged mistreatment, neglect, and abuse of residents and misappropriation of resident property they observe, hear about, or suspect to a supervisor and the administrator." The Policy documents "Employees of this facility who have been accused of mistreatment, neglect, abuse, or misappropriation of resident property will be immediately removed from resident contact until the results of the investigation have been reviewed by the administrator or designee. Employees accused of alleged mistreatment, neglect, abuse or misappropriation of resident property shall not complete their shift as a direct care provider to residents." The Policy documents "Supervisors shall immediately inform the administrator or his/her designated representative (specified by the administrator in the case of a planned absence) of all reports of potential/alleged mistreatment, neglect, and abuse of residents and misappropriation of resident property. Upon learning of the report, the administrator or designee shall initiate an investigation." According to Resident Census and Conditions of Residents report dated 2/02/15 document 55 residents reside in the facility.	F 225		
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		

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F 226	Continued From page 5 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to operationalize the Abuse Prevention Program Facility policy by failing to report an allegation of verbal/mental abuse immediately to the administrator, failing to thoroughly investigate an allegation of abuse, failing to protect residents from potential further abuse, and failing to report to the State Survey and Certification agency. The failing also failed to check references on nine of ten prospective employees prior to allowing them to work at the facility. These failures have the potential to affect all 55 residents residing in the facility. Findings include: 1. The Abuse Prevention Program Facility Policy dated 11/11/11 documents "Employees are required to immediately report any occurrences of potential/alleged mistreatment, neglect, and abuse of residents and misappropriation of resident property they observe, hear about, or suspect to a supervisor and the administrator." The Policy documents "Employees of this facility who have been accused of mistreatment, neglect, abuse, or misappropriation of resident property will be immediately removed from resident contact until the results of the investigation have been reviewed by the administrator or designee.	F 226		

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F 226	Continued From page 6	F 226		

Employees accused of alleged mistreatment, neglect, abuse or misappropriation of resident property shall not complete their shift as a direct care provider to residents." The Policy documents "Supervisors shall immediately inform the administrator or his/her designated representative (specified by the administrator in the case of a planned absence) of all reports of potential/alleged mistreatment, neglect, and abuse of residents and misappropriation of resident property. Upon learning of the report, the administrator or designee shall initiate an investigation."

The Resident Council Minutes dated 1/22/15 document, "There was one complaint that a nurse (E5, Certified Nurse's Assistant) is yelling and being rude to resident."

On 2/03/15 at 12:00 PM, E4 (Activity Director) stated that during the resident council meeting on 1/22/15 R17 alleged that a nurse (E5) was yelling and being rude to her. E4 stated that she did not go immediately to E1 (Administrator) and report the allegation.

On 2/04/15 at 11:30 PM, E1 stated that she was unaware that the Resident Council Meeting Report documented that "There is one complaint of a nurse yelling and being rude." until 2/03/15. E1 stated the facility policy states that the administrator should have been notified. E1 stated that E4 should have reported the allegation of verbal/mental abuse to her immediately.

2. The Abuse Prevention Program Facility Policy dated 11/11/11 documents "Prior to a new employee starting a work schedule this facility will: Initiate a reference check from previous

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F 226	Continued From page 7 employer(s)" On 2/04/15 at 11:30 PM, E1 confirmed that E11 (CNA) was hired on 12/30/14, E12 (CNA) was hired on 9/29/14, E5 was hired on 2/17/14, E13 (CNA) was hired on 11/06/14, E14 (CNA) was hired on 10/23/14, E15 (CNA) was hired on 7/25/14, E16 Nursing Assistant was hired on 12/02/14, E17 (CNA) was hired on 3/19/14, and E18 (CNA) was hired on 8/29/14. E1 confirmed that E11, E12, E5, E13, E14, E15, E16, E17, and E18 were checked against registry and had no disqualifying conditions. E1 confirmed that reference checks were not completed on E11, E12, E5, E13, E14, E15, E16, E17, or E18. E1 stated that E3 did not know that she had to check references on new employees. According to Resident Census and Conditions of Residents report dated 2/02/15 document 55 residents reside in the facility.	F 226		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 314		

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F 314	Continued From page 8	F 314		

review the facility failed to implement pressure relieving interventions and failed to maintain a dressing to a pressure sore as ordered by the physician for one of four residents (R16) reviewed for pressure sores in the sample of fourteen.

Findings include:

The Physicians Order Sheet (POS) dated 2/01/15 documents that R16 has a stage two pressure sore to her left upper posterior thigh. The POS dated 2/01/15 documents a treatment order to cleanse left upper posterior thigh with cleanser, apply hydrogel and bordered foam daily.

The Minimum Data Set dated 1/12/15 document's that R16 has a pressure reducing device for chair and R16 is frequently incontinent of urine.

On 2/02/15 at 2:30 PM, E6 (Registered Nurse) confirmed that R16 has been sitting in a dining room chair without a pressure relieving cushion since 11:30 am. E6 stated that R16 does not sit in her room very often and prefers to sit in the dining room most of the day. E6 stated that the pressure sore to R16's thigh is caused from R16 scooting and rocking in the dining room chair.

On 02/02/15 at 2:40 PM, E3 (Assistant Director of Nursing) stated that she is the wound nurse for the facility. E3 stated she is not sure why R16 does not have a pressure relieving cushion in her chair. E3 stated that she thinks a pressure relieving cushion would be beneficial to R16 because of the amount of time she spends in the dining room chair.

On 02/02/15 at 3:05 PM, E6 provided treatment to R16's pressure sore. R16 had a 1.5 centimeter

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F 314	Continued From page 9 by 0.75 centimeter stage two pressure sore to her left upper posterior thigh. R16's pressure sore was not covered with bordered foam. On 02/02/15 at 3:15 PM, E6 stated that at approximately 6:30 am she removed R16 dressing from her left upper posterior thigh. E6 stated that she did not apply a new dressing because she did not see R16's pressure sore and she felt the pressure ulcer was healed. E6 confirmed that R16's pressure sore was undressed from 6:30 am to 3:00 PM. The 01/2002 Aseptic Wound and Skin Treatment Procedure documents "clean the wound as ordered and apply clean dressing as ordered."	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to prevent cross contamination during perineal care for one of five residents (R16) reviewed for urinary tract infections in the sample of fourteen.	F 315		

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F 315	Continued From page 10 Findings include: The Minimum Data Set dated 1/12/2015 documents R16 is frequently incontinent of urine. The Laboratory Data Sheet dated 12/29/14 documents R16's urine culture grew greater than 100,000 colonies of Escherichia Coli. The Nurses Notes dated 1/01/15 at 10:15 AM documents an order for Nitrofurantoin 100 milligrams, one tablet by mouth twice a day for a week for a Urinary Tract Infection. On 2/03/15 at 8:55 am, R7 Certified Nurse's Assistant (CNA) and E8, CNA provided perineal care to R16. E3, Assistant Director of Nursing, was present. R16 was standing up at the toilet. E8 wiped R16 from the back of her perineum to the front of her perineum with a washcloth. E8 confirmed that R16 had a bowel movement. On 2/03/15 at 9:05 am, E3 confirmed that E8 wiped R16 from the back of her perineum to the front of her perineum. E3 stated that E8 should not have wiped R16 from the back of her perineum to the front of her perineum. E3 stated that she teaches the CNA's to wipe from the front of the perineum to the back of the perineum and teaches them that wiping in the opposite direction causes urinary tract infections. The 09/21/10 Perineal Cleansing policy documents "use long strokes from the most anterior down to the base of the labia" and "wash peri-anal area thoroughly with each stoke beginning at the base of the labia and extending up over the buttocks."	F 315		

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F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to supervise safe storage of a sharp razor, having the potential to effect two sampled residents (R13 and R17) and 11 residents on the supplemental sample (R20, R22, R24, R31, R32, R35, R37, R46, R47, R49, R53), and safe storage of compressed oxygen tanks, having the potential to effect two sampled residents (R8 and R9). 1. On 2/2/15 at 12:00 PM a disposable blade style shaving razor was on the television in R8's room. Along with the razor were 4 refill blade cartridges. The same razor remained on the television on 2/3/15 at 10:00 AM, and 2/4/15 at 10:00 AM. On 2/4/15 at 10:15 AM E2, Director of Nursing (DON), stated, "(R8) has a lock box for the razors, (R8) knows he is supposed to keep the razors in the lock box. I don't know why (R8) didn't have it in the box the last 3 days." The facility's list of cognitively impaired independently mobile residents provided 2/5/15 documents 13 residents, excluding residents	F 323		

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F 323	Continued From page 12 residing on the alarmed Severe Mental Illness Unit, who are independently mobile with or without an assistive device and also experience cognitive impairment. 2. On 2/4/15 at 3:00 PM a compressed oxygen tank with regulator installed was unsecured in the oxygen storage building. The facility's resident smoking area is in the direct vicinity and two residents were smoking in the immediate vicinity (R8 and R9). On 2/4/15 at 3:00 PM E21, Maintenance Supervisor, stated, "I tell the staff all the time not to leave oxygen tanks loose in here like that."	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 329		

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F 329	Continued From page 13 contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to attempt antipsychotic medication gradual dose reductions for two of six residents (R13, R17) reviewed for psychoactive medications in the sample of 14. Findings include: 1. The Physician's Order Sheet dated 1/23/15 documents that R17 has diagnoses of Dementia and Psychosis and that R17 has an order to receive Seroquel (antipsychotic) 100 milligrams (mg) twice daily. The Psychotropic Medication Assessment dated 9/24/14 documents that Seroquel 100 mg twice daily was ordered for R17 on 12/9/13 for a diagnosis of Psychosis. The Pharmacy Recommendation form dated 3/28/14 documents that on that date a Z1 Pharmacist recommended that R17's Seroquel dose be reduced to 75 mg in the morning and 100 mg in the evening. The form states that if the dose reduction is not warranted the benefits versus risks of continued usage of the mediation should be documented. The form documents that Z2 Nurse Practioner disagreed with the recommendation and Z2 did not document a reason for the refusal. The Behavior Monitoring Record dated October 2014 documents target behaviors for R17 as	F 329		

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	146117	A. BUILDING _____ B. WING _____	02/05/2015

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F 329	Continued From page 14	F 329		

"rude to staff" and "hitting staff" and documents no episodes occurring during that month. The November 2014 Behavior Monitoring Record documents "yelling at residents/staff" and "tearing up other peoples property" as target behaviors for R17 and documents one episode of ripping up the cover on a library book and one episode of yelling. The December 2014 Behavior Monitoring Record documents target behaviors for R17 as "refusing to do anything", "rude to staff/residents" and "hitting staff". The December 2014 Behavior Monitoring record documents R17 had one episode of refusing to do anything and no other behaviors. The January 2015 Behavior Monitoring Record documents that R17 had one episode of refusing to help herself and one episode of being rude to staff.

On 2/4/15 at 10:15 AM, E9 Social Service Director stated that R17 has behaviors of being rude to staff and residents. E9 also stated that when R17 returned from a hospitalization she had behaviors of refusing to help herself, but that behavior has resolved. On 2/4/15 at 10:30 AM, E2 Director of Nurses stated that a gradual dose reduction of R17's Seroquel has not been attempted since the medication was started (on 12/9/13).

2. The POS dated 1/23/15, documents that R13 has diagnoses of Dementia with Agitation and Bipolar Affective Disorder and that R13 has an order for Geodon (antipsychotic) 80 mg twice daily for Dementia Related Psychosis. The Psychotropic Medication Assessment dated 1/12/15 documents that the Geodon was ordered for R13 on 4/19/07. The Psychotropic Medication Assessment dated 10/20/14 documents "no behaviors, very pleasant, visits with other

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F 329	Continued From page 15 residents, home visits". The Psychotropic Medication Assessment dated 1/12/15 documents "no changes from (10/20/15 assessment)". The Behavior Monitoring Records dated January 2015 through August 2014 document no behaviors for R13. On 2/3/15 at 3:00 PM, E9 stated that R13 does not have target behaviors and confirmed that R13 has had no behaviors since she began working at the facility in August 2014. On 2/4/15 at 11:20 AM, E2 stated that a gradual dose reduction for R13's Geodon has not been attempted at the facility since since the medication was started. Reduction of Psychotropic Medications Protocol dated 1/2002 states "(psychotropic medication) reduction shall be attempted at least twice in one year unless the physician documents the need to maintain the resident regimen....." and "dosage reductions may be attempted whenever the residents behavior patterns indicate to the attending physician that a dosage reduction may be appropriate."	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to store foods in a manner to prevent potential for contamination and failed to maintain cleanliness of food contact surfaces. These failures have the potential to effect all 55 residents in the facility.

1. On 2/3/15 at 10:30 AM a partial package of raw pork sausage, removed from it's original packaging and re-wrapped in sheet plastic wrap, was stored in freezer 3. Stored below the raw pork sausage were frozen prepared pancakes, also removed from their original cardboard box and stored in the freezer inside the original plastic bag.

On 2/3/15 at 10:30 AM E10, Dietary Manager (DM), stated, "That sausage is raw and it should be on the bottom shelf."

2. On 2/4/15 at 11:45 AM the food processor had a white substance on the cutting edge of the blade and particles of dried food debris on the main shaft of the blade.

On 2/4/15 at 11:45 AM E10, DM, stated, "I don't know what the white stuff is, it flakes off, but that (dried particles) is food."

3. On 2/3/15 at 10:40 AM a stainless steel tray in the refrigerator on the second shelf up from the bottom contained 12 glasses of pre-poured milk. The glasses of milk were not covered to prevent food and packaging debris from higher shelves entering the milk glasses.

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F 371	Continued From page 17 On 2/3/15 at 10:40 AM E10, DM, stated, "Those glasses need to be covered." The facility's "Resident Census and Conditions of Residents" dated 2/2/15 documents 55 residents reside in the facility.	F 371		