Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009765	A. BUILDING: ______ B. WING ______	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATSEKA REHAB & HLTH CARE CTR	715 EAST RAYMOND ROAD WATSEKA, IL 60970

(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
S 000	Initial Comments Complaint Investigation: 2264531/IL147829, FRI of 6/9/2022/IL147861, FRI of 6/6/2022/147865, FRI of 6/19/2022/IL148328 & FRI of 6/20/2022/IL148234	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210c) 300.1210d)1 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. 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.	S9999	**Attachment A** **Statement of Licensure Violations**	

s Department of Public Health
IRATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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These Requirements were NOT MET as evidenced by:

Failures at this requirement required more than one Deficient Practice Statement.

A.) Based on observation, interview, and record review the facility failed to ensure R12 was not subjected to physical violence by another resident, (R11). R11 forcibly held a pillow over R12's face, impeding R12's breathing.

R11 and R12 are two of ten residents reviewed for abuse in a sample list of 23 residents.

Findings include:

On 6/23/22 at 12:00PM V12, Certified Nurse's Aide (CNA) stated "I was checking residents on the Dementia Unit on 6/20/22 at about 1:30AM. I went into the resident's room where (R11) and (R12) were roommates. (R11) was straddling (R12). (R11) was holding a plastic pillow without a pillowcase on (R12's) face. The pillow was interfering with (R12's) breathing. (R12) was too weak to push (R11) off him. (R12) did not lose consciousness. (R12) was visibly shaken. I was able to get (R11) off (R12). I called (V13), Licensed Practical Nurse. She called Emergency Medical Services. (R11) was taken to the hospital and has not returned."

R11's hospital discharge dated 6/17/22 includes the following diagnoses: Altered Mental Status, Dementia, Diabetes Mellitus and Encephalopathy.

R11's hospital transfer sheet dated 6/17/22 documents "during hospitalization (R11) had recurrent episode of agitation and was started on

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Seroquel (antipsychotic) 25 milligrams twice daily. (R11) should follow-up with a facility doctor within 2-3 days." There is no documentation to support a facility doctor followed up on this as ordered. There is no documented Care Plan for R11 from 6/17/22 until he left the facility 6/20/22. Hospital Critical Care note also contained in R11's 6/17/22 transfer sheet documents "(R11's) son reports that they have had difficulty managing with the patient at home. He (R11) does become angry and combative when questioned regarding his insulin and therefore is unclear if (R11) is compliant with his medication."

On 6/29/22 at V20, (R11's) family member stated "(R11) was getting violent at home before he fell and went to the (hospital). I asked him to show me his glucose monitor so I could get him the right test strips. (R11) got angry and pulled a knife from the sink and tried to cut me with it. We told the nurses at the hospital, so they knew. (While at the hospital) (R11) pulled (family member) (V21's) hair and would not let go. The nurses had to make him let go. The facility (nursing home) never talked to me to find out if (R11) had any aggressive behaviors. I thought the hospital would tell them."

R11's nurse's note dated 6/17/22 at 7:00PM documents "(R11) admitted and began wandering. Unable to assess or take vital signs related to language difference (R11's dominant language is Spanish). (R11) cannot be redirected." R11's nurse's note dated 6/17/22 at 10:00PM documents "(R11) has moved furniture in his room blocking door to bathroom." There are no subsequent nurse's notes for (R11) until 6/20/22 at 1:30AM which documents "CNA (Certified Nurse's Aide) (V12) called nurse (V13) to (R11's) room. (CNA) stated (R11) has a pillow

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over roommate's (R12's) head. Witness Statement was obtained. Emergency Medical Services were called after resident (R11) was removed to ensure roommate's safety. Resident (R11) threw (soda) pop can at CNA (V12)."

On 6/23/22 at 3:30pm, V1, Administrator confirmed that the facility is rushed to look at prospective (resident) admits and are not always aware of behaviors that may not be safe for the facility. V1 confirmed that Nursing looks at the medications and documented notes. V1 also confirmed that Nursing should have seen that R11 was started on Seroquel (anti-psychotic) in the hospital. V1 stated "My opinion of (R11's) incident was because of the language barrier. (R11) was brought to a strange place and could not understand English and we did not have a communication tool in place."

R11's Nursing Admission Assessment by V3, Acting Director of Nursing confirmed R11 spoke "limited English." dated 6/17/22 at 2:00PM documents "Dominant Language: Spanish Limited English."

On 6/23/22 at 1:00PM V3, Acting Director of Nursing stated "(R11) spoke only a little English."

R12's Activity Admission Care Plan (unsigned) dated 6/17/22 documents (R12) is "Alert, Cooperative, and Forgetful." R12's Activity Admission Care Plan (unsigned) dated 6/17/22 also documents under the heading "Identified need Plan Areas: Intellectual challenges, wandering, cognitive/memory (issues), and communication."

R12's psychosocial assessment dated 6/16/22 by V22, Dementia Director documents the only

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S9999	Continued From page 4 behaviors exhibited by (R12) are "Wanders/Paces." On 6/27/22 at 3:00PM R12 was sitting on the patio. He was not able to verbalize his name or where he was. He has no recollection of the incident with R11 when questioned. R12 appeared weak and frail. He can ambulate but displayed a shuffling unstable gait. Both his ankles were edematous. He muttered to himself, but he is unaware of his surroundings. (A)	S9999		