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 05/03/2024

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 Survey: 2463430/IL172637 & FRI of 4/24/2024/IL172633	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 300.610a) 300.1210b) 300.1210c) 300.12010d)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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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	S9999		

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/16/24

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 05/03/2024

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
S9999	Continued From page 1	S9999		

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:

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.

These Requirements were NOT MET as evidenced by:

Based on interview and record review the facility failed to protect the residents' right to be free from physical abuse by another resident. This failure affected three of five residents (R1, R2, R3) reviewed for abuse in the sample of nine. R1 pushed R2 who sustained skin tears to both elbows. R1 shoved R3 who fell into the wall, hit her head/back against the wall, then fell to the ground. R3 complained of back pain and was sent to the emergency room.

Findings Include:

The facility's Abuse Prevention Program dated 11/28/16 documents the facility affirms the right of it's residents to be free from abuse or mistreatment. Physical abuse is the infliction of injury on a resident that occurs other than by

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 05/03/2024

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
S9999	Continued From page 2	S9999		

accidental means. Physical abuse can include such things as hitting, slapping, pinching, and kicking.

The Abuse Investigation Summary dated 4/24/24 documents on 4/24/24 at 6:15 PM R1 and R2 were involved in an incident of physical aggression. R1 and R2 were ambulating in the hallway. R1 stopped walking and as R2 walked past, R1 shoved R2 to the floor. R2 sustained skin tears to both elbows.

The Abuse Investigation Summary dated 4/24/24 documents on 4/24/24 at 6:30 PM R1 and R3 were involved in an incident of physical aggression. R1 was standing in the hallway and R3 walked past him. As R3 walked past, R1 shoved R3. R3 stumbled but caught herself before falling to the ground.

The Abuse Investigation Summary dated 4/26/24 documents on 4/26/24 at 1:30 PM R1 and R3 were involved in an incident of physical aggression. R1 was standing in the hallway and R3 walked past him and appeared to reach her hand out towards R1. As she did this, R1 shoved R3. R3 hit the wall behind her and fell to the ground.

R1's Medical Diagnoses sheet dated May 2024 documents R1 is diagnosed with Alzheimer's Disease, Altered Mental Status, and Delusional Disorders.

R1's Psychosocial Evaluation dated 3/9/24 documents R1 is uncooperative, wanders, paces, enters other resident's bedrooms uninvited, has delusions, is physically aggressive and abusive, violates the personal space of others and does not understand social limits.

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 05/03/2024

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
S9999	Continued From page 3 R1's Wandering/Elopement Evaluation dated 3/11/24 documents R1 is ambulatory and wanders. R1 also may become agitated when approaching others during wandering. R1's Minimum Data Set (MDS) dated 3/11/24 documents R1 has severe cognitive impairment. R1 also has physical behavioral symptoms directed towards others (hitting, pushing, grabbing, kicking). R1's Care Plan dated 2/22/24 documents R1 is cognitively impaired and has the potential to be physically aggressive related to Dementia, Alzheimer's Disease, Pain, and Delusional Disorder. The same Care Plan documents R1 has a behavior problem with peers in his personal space related to Dementia. Staff are to intervene as necessary to protect the rights and safety of others. R2's Medical Diagnoses sheet dated May 2024 documents R2 is diagnosed with Dementia with Behaviors, Anxiety, and Insomnia. R2's Care Plan dated 3/11/24 documents R2 is cognitively impaired and wanders aimlessly with his head down. R2 has behaviors that others may find disruptive or socially inappropriate such as intruding into other's personal space. Other residents may seek reprisal against R2. R3's Medical Diagnoses sheet dated May 2024 documents R3 is diagnosed with Bipolar Disease, Alzheimer's Disease, Dementia, Hallucinations, Anxiety, Depression, and Wandering. R3's Care Plan dated 3/11/24 documents R3 is cognitively impaired and wanders. R3 has the	S9999		

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 05/03/2024

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
S9999	Continued From page 4 potential to be verbally aggressive related to Depression and Cognitive Deficits. On 5/2/24 at 2:10 PM V1 Administrator confirmed R1 has a history of physical aggression towards staff and other residents. V1 confirmed R1 is ambulatory, wanders, and needs supervision. V1 confirmed R1, R2, and R3 are all cognitively impaired residents who reside on the facility's locked dementia unit. V1 stated during the abuse investigation for incidents on 4/24/24, R1 was visualized on video surveillance walking down the hall, stopping and then as R2 passed him in the hallway, R1 shoved him and R2 fell to the floor. V1 stated as staff were attending to R2, R1 was standing in the group of residents that started to congregate in the area. R3 then started to walk through the group of people surrounding R2 and R1 preceded to shove R3. R3 stumbled into the wall but did not fall to the ground. V1 confirmed facility staff should have removed R1 from the hallway after he shoved R2 and in not doing so they did nothing to protect other residents from becoming victims. V1 stated one staff should have attended to R2 and one staff should have removed R1 from the area and supervised him so he was not able to be aggressive with anyone else. V1 confirmed R2 sustained an abrasion to each elbow from the fall. After R2 was attended to, R1 was sent to the hospital for a psychiatric evaluation. The hospital performed diagnostic tests and found nothing acute. The hospital said R1 was not acting aggressive and sent R1 back to the facility the next morning on 4/25/24. V1 confirmed when R1 returned, the staff did not implement increased supervision or any other new intervention to ensure R1 would not be physically aggressive towards any other residents. R1 went about his business as usual. V1 Administrator confirmed the staff need to be	S9999		

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 05/03/2024

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
S9999		S9999		

Continued From page 5

able to keep residents safe from other resident's aggression. V1 also confirmed during the abuse investigation for the incident on 4/26/24, R1 was visualized on video surveillance again walking down the hallway. R1 stopped in the hallway and R3 passed R1 walking down the hallway. As R3 passed R1, she reached towards R1 and R1 shoved R3. R3 fell into the wall, hit her head/back against the wall, and fell to the ground. R3 complained of back pain and was sent to the emergency room but no acute injuries were found. R1 was again sent to the the hospital for a psychiatric evaluation and remains there at this time.

(B)

Licensure Violations 2 of 2

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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

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 05/03/2024

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
S9999	Continued From page 6	S9999		

Continued From page 6

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:

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.

These Requirements were NOT MET as evidenced by:

Based on observation, interview and record review the facility failed to adequately supervise and maintain a safe environment for residents, thoroughly investigate a fall, and failed to include a focus area, goal and interventions for a resident. These failures affect three residents (R2, R4, R6) out of three residents reviewed for falls in a sample list of nine residents. R6

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 05/03/2024

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
S9999	Continued From page 7	S9999		

sustained a dislocated Right Fourth finger and Left Foot Contusion as a result of an unwitnessed fall when the resident was found with dresser on top of him.

Findings Include:

1. R6's Electronic Medical Record (EMR) documents R6's medical diagnoses as Dislocated Right Fourth Finger, Contusion to Left Foot, Moderate Dementia with Agitation, Delusional Disorder, Dysthymic Disorder and history of Embolism and Thrombosis of Deep Veins of Left Lower Extremity.

R6's Minimum Data Set (MDS) dated 4/16/24 documents R6 was severely cognitively impaired. This same MDS documents R6 requires supervision with toileting, dressing, personal hygiene, transfers, ambulation and maximum assistance with bathing.

R6's Care Plan intervention dated 2/29/24 documents staff are to assist with ambulation and transfers. This same careplan documents an intervention dated 3/11/24 that instructs staff to cue, orient and supervise as needed.

R6's Fall Risk Evaluation dated 4/13/24 documents R6 as a risk for falling.

R6's Nurse Progress Note dated:

-4/23/24 at 8:30 PM documents "(R6) was found on the floor by (V17) Certified Nurse Aide (CNA) when she heard a loud noise coming from (R6's) room. (R6) was on the floor laying on right side with dresser on top of him. (V17) CNA removed the dresser and came for help. On entering room (R6) is sitting on his bottom with legs bent. On

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 05/03/2024

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
S9999	Continued From page 8	S9999		

assessment area found to top of Left Foot where skin had been sheared and on further assessment area found to his Right ring finger, which is bent not aligned as it should be."

-4/24/2024 at 1:53 AM documents "(R6's) Unwitnessed event was first noted on 04/23/2024 8:30 PM. Just prior to/at the time of the event (R6) appears to have been in his room going through his dresser drawers. (V17) Certified Nurse Aide (CNA) working on unit had just walked by (R6's) room taking another resident to his room and (V17) saw (R6) at his dresser in the top drawer. (V17) CNA heard a loud noise from next door, went immediately to the room and found (R6) on the floor with dresser on top of him. Review of (R6's) pain parameters reveals (R6) rates pain level as 7. Non-verbal sounds of pain or crying at the time of the event. Facial expressions (e.g.. grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw) at the time of the event. Protective body movements or grasping at body at the time of the event. New onset pain observed/reported. Pain location includes upper extremity limb pain.

-4/24/2024 at 9:09 AM documents "Interdisciplinary Team Meeting (IDT) Falls-Root Cause- (R6) fidgeting with dresser and fell."

R6's Fall Investigation dated 4/23/24 documents R6 had an unwitnessed fall in his room at 8:30 PM on 4/23/24. This same fall investigation documents V17 Certified Nurse Aide (CNA) witnessed R6 in R6's room going through his dresser drawers prior to R6's fall. This investigation documents V17 did not assist R6 at that time. This same investigation documents V17 "saw (R6) at his dresser in the top drawer". V17 heard R6 yelling out and found R6 on the

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 05/03/2024

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
S9999	Continued From page 9	S9999		

floor with dresser on top of him. "When moving dresser, a blanket was found under it which made in unbalanced." R6's Fall Investigation documents R6's Right Fourth finger and top of Left Foot were injured.

V17's Fall Investigation statement dated 4/23/24 for R6's fall on 4/23/24 documents "(V17) walked in (R6's) room and the lights were on and (R6) was between both beds with the large dresser on top of (R6). (V17) got the dresser off of him and notified the nurse immediately."

R6's Hospital records dated 4/23/24 document "(R6) was sent to the emergency department via ambulance service from facility for a report that (R6) had dresser fell on (R6's) Right Hand. (R6's) Right Hand is swollen and Right Fourth finger is angled over Right Fifth finger. Cold pack applied to Right Hand. Left Foot appears swollen as well. (R6's) Right Fourth Finger was reduced and placed finger in aluminum splint. (R6's) Right Fourth digit was anesthetized via digital block with subcutaneous injection of eight cc of 1% Lidocaine." This same hospital record documents R6's diagnosis for this hospital stay as "Traumatic dislocation of joint of finger, Fall and Contusion of Left Foot."

R6's X Ray results of Right Hand dated 4/23/24 documents "Impression: Dislocation of the Fourth finger on Right Hand at the PIP (Proximal Interphalangeal) joint."

R6's Final Incident Report to the State Agency dated 4/23/24 documents R6 was in his room 'fidgeting' with his dresser. Upon entering R6's room, R6 was noted to be on floor in between the bed with the dresser on top of him. "Upon assessment of (R6), he was noted to have an

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 05/03/2024

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
S9999	Continued From page 10	S9999		

abrasion to top of his Left Foot and Right Fourth finger was noted to be bent." R6 was sent to the emergency room where he was treated for an abrasion to top of Left Foot and dislocated Right Fourth finger. This same report documents "Discharge Instructions from emergency room stated (R6's) Fourth Finger on Right Hand was dislocated, have reduced it back into place, wear splint on finger as needed for comfort and follow up with Orthopedic." R6's Final Report documents "The facility believes that (R6) was rummaging through dresser, attempted to remove one of the drawers, causing dresser to tip over onto resident."

On 5/2/24 at 3:32 PM R6 wandering in dining area tapping his fingers on dining room tables to music that was playing. No staff present in dining area.

On 5/3/24 at 1:10 PM V4 Dementia Unit Director stated R6 has a history of rummaging in his dresser drawers. V4 stated R6 likes to remove the clothes from the drawers and refold them. V4 stated R6 'is very busy' and requires a lot of supervision. V4 stated R6 has no safety awareness and should be supervised more closely to help prevent falls. V4 stated "If (V17) Certified Nurse Aide (CNA) had assisted R6 as she saw him rummaging in his drawers prior to his fall, then he probably would not have fallen that time."

On 5/3/24 at 2:45 PM V1 Administrator stated R6's fall could have been prevented if the staff would have made sure R6's surroundings were safe. V1 Administrator stated she was unaware of R6's dresser having a blanket underneath it which caused it to be off balance. V1 stated "If the staff would have just moved the blanket from

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 05/03/2024

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
S9999	Continued From page 11	S9999		

out from under the dresser, (R6) probably would not have fallen and dislocated his finger." V1 stated the staff failed to make sure R6's dresser was stable which in turn caused R6 to fall and dislocate his finger. V1 Administrator stated R6 had advanced Dementia and cannot be expected to provide for his own safety. V1 stated "The staff are supposed to do that and they did not."

2. R4's Electronic Medical Record (EMR) documents admitted to facility on 10/28/23 with medical diagnoses of Severe Dementia with Psychotic Disturbance, Thyrotoxicosis with Diffuse Goiter, Intestinal Obstruction, Intestinal Adhesions with Partial Obstruction, Alzheimer's Disease, Ascites, Repeated Falls, Weakness, Urinary Incontinence, Incontinence of Feces and Need for Assistance with Personal Care.

R4's Minimum Data Set (MDS) dated 11/8/23 documents R4 was severely cognitively impaired. This same MDS documents R4 was dependent on staff for toileting, personal hygiene, bathing and maximum assistance for dressing.

R4's Fall Risk Assessment dated 10/29/23 documents R4 as a risk for falling.

R4's Care Plan initiated on 10/31/23 does not include a focus area, goal nor interventions for R4's being at risk of falling until 11/7/23.

R4's Electronic Medical Record (EMR) documents R4 was last observed at 1:41 AM on 11/5/23 prior to being found on floor at 7:05 AM on 11/5/23.

R4's Nurse Progress Noted dated 11/5/23 at 7:50 AM documents "At 7:05 AM (R4) was observed lying on the floor, noted with small amount of

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 05/03/2024

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
S9999	Continued From page 12	S9999		

blood to her mouth/oral area and small amount of blood also noted on the floor next to her head. (R4's) Right bottom lip noted swollen, Right side of face noted red, bump to Right anterior scalp area, no visual laceration noted to head or anywhere else. . (R4) was noted nonverbal, per attending (V7) Certified Nurse Aide (CNA) this is not her norm."

R4's Fall Investigation dated 11/5/23 documents R4 had an unwitnessed fall in R4's room on 11/5/23. This same investigation documents time of R4's fall was 7:05 AM. This same investigation report documents R4 obtained an injury to the top of her scalp, level of consciousness was 'Stuporous' and mobility was 'ambulatory without assistance'. Root cause documented as self transfer. This same investigation documents "(V3) (R4's) Power of Attorney (POA) stated (R4) fell a lot at home and that is one of the main reasons she was placed at facility."

On 5/2/24 at 2:10 PM V7 Certified Nurse Aide (CNA) stated V7 was the CNA on duty assigned to R4 the morning (11/5/23) R4 had an unwitnessed fall in her room. V7 stated V7 was scheduled from 6:00 AM-6:00 PM. V7 stated V7 came in that day (11/5/23) and started at the opposite end of the hall getting people up. V7 stated "I (V7) did not see (R4) that morning until I went in to get her up. The nurse was on another hall and the other CNA was with me. No one could have checked on (R4). The night shift had told us that (R4) had been up all night rummaging through drawers and being very busy. I thought (R4) was just sleeping since I hadn't seen her that morning. Once I got to (R4's) room, there was blood on the floor where she had a bloody lip. (R4) was wearing two pairs of pants and had put her head through the sleeve of her own shirt.

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 05/03/2024

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
S9999	Continued From page 13	S9999		

I stayed with (R4) until the ambulance came and took her to the hospital. (R4) was trying to hold her head but I encouraged her not to do that since we (facility) didn't really know how bad she was hurt yet. (R4) moaned like she was in pain."

On 5/3/24 at 1:15 PM V1 Administrator stated R4 fell on 11/5/23. V1 stated the exact time of the fall unclear due to the last time R4 was checked on was 1:41 AM. V1 stated "We (facility) have no way to show that (R4) was checked from 1:41 AM-7:05 AM when (R4) was found laying on the floor of her room." V1 confirmed there is no documentation of R4 being monitored or assisted with cares during that time frame. V1 stated "(R4) could have been laying there for awhile. We (facility) know that (R4) was up and down all night. We (facility) know that (R4) was found at 7:05 AM. The staff should have been monitoring (R4) more closely, especially since she was up and about in the middle of the night already. (R4) ended up going to the hospital with a bloody fat lip that could have been prevented if our staff were watching her better. I am thankful (R4) wasn't hurt any worse."

3. R2's undated Medical Diagnosis List documents R2's medical diagnoses as Dementia, Insomnia and Anxiety.

R2's Minimum Data Set (MDS) dated 2/25/24 documents R2 as severely cognitively impaired. This same MDS documents R2 as requiring maximum assistance with toileting, dressing, personal hygiene and supervision with transfers and mobility.

R2's Care Plan intervention dated 3/12/24 instructs staff to Assist (R2) with ambulation and transfers. This same care plan documents an

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 05/03/2024

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
S9999	Continued From page 14	S9999		

intervention dated 3/11/24 for R2 to be supervised on a one to one continual basis when up and walking.

R2's Nurse Progress Note dated 4/22/24 at 1:08 PM documents "Staff was called to hall after being informed (R2) had a fall. (Facility was) Informed by (V18) visitor that (R2) walked into cart and fell to buttocks and did not hit his head. Assessed (R2) for injury and none noted."

R2's Nurse Progress Note dated 4/22/4 at 1:11 PM documents "Just prior to/at the time of the event (R2) appears to have been pacing. Location of the event: Hallway. Description of the environment: (R2) was walking up and down hall and housekeeping cart in the middle of the hall. Facility staff actions/interventions and response at the time of the event: Staff instructed to stay with (R2) at all times."

R2's Fall investigation dated 4/22/24 documents "(V18) Visitor saw (R2) walk into (housekeeping) cart, then fell to floor on buttocks. Root Cause: Clutter in hallway."

On 5/2/24 at 3:35 PM R2 was walking in hall with V10 Unit Aide. V10 walking with R2 side by side or in front/back of R2 depending on space available. R2 walked into an unoccupied room with two beds, two dressers and an attached bathroom. R2 was walking in a narrow space about five feet long between a bed and wall up to bedside dresser in corner. There was not enough room for V10 to walk with R2 in that space, so V10 Unit Aide waited at the end of the bed and then when R2 walked out of the area, V10 would again walk with R2. V10 Unit Aide did not try to re-direct R2 out of that narrow space. R2 paced back and forth in that same space several times.

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 05/03/2024

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
S9999	Continued From page 15	S9999		

R2 became unsteady twice during the time he was pacing back and forth in that same space.

On 5/2/24 at 3:40 V10 Unit Aide stated V10 is assigned to 'constantly be with (R2)'. V10 stated R2 paces all day but at night will sleep through the night 'pretty well'. V10 stated V10 should stay directly with R2 at all times due to R2 falls frequently and has an unsteady gait. V10 Unit Aide stated V10 and R2 would not both 'fit' in the space between the bed and wall so V10 did not walk with R2 in that space. V10 Unit Aide stated "I saw (R2) get a little wobbly and hoped he wouldn't fall again. I wouldn't have been able to help him. I should have tried to get (R2) to just walk somewhere else."

On 5/3/24 at 1:05 PM V4 Dementia Unit Director stated R2 normally walks around the unit 'a lot' with his head down and eyes closed. V4 stated R2 was on a one to one continual observation when R2 fell on 4/22/24. V4 stated (V12, Activity Aide) should have redirected R2 away from the housekeeping cart instead of 'just allowing (R2) to run into the housekeeping cart and fall because he was trying to maneuver around it'. V4 stated "(R2) has no safety awareness and doesn't know what he is doing. The staff need to be paying closer attention to (R2) so he doesn't fall so much. We (facility) all know that (R2) falls and needs a lot of guidance."

On 5/3/24 at 1:55 PM V12 Activity Aide stated V12 directly witnessed R2 walk into the housekeeping cart causing him to fall on 4/22/24. V12 stated "I don't remember seeing anyone else with (R2). I was not the 'one to one' assigned to (R2) that day. I was walking out of the dining room because it was right after lunch so I was helping other residents get back to their rooms or

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 05/03/2024

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
S9999	Continued From page 16	S9999		

other areas. (R2) was pacing and he walked right into the housekeeping cart. There were no staff directly next to (R2). That big yellow housekeeping cart was right in the middle of the hall in everyone's way. (R2) keeps his head down and eyes closed when he walks so he would not have even seen it. This is a Dementia unit. We (staff) have to keep the aisles and all the areas clear of fall hazards. Many of the residents do not have any awareness of their surroundings and could get hurt on something like that."

On 5/3/24 at 2:40 PM V1 Administrator stated R2 fell on 4/22/24 due to a housekeeping cart sitting in the middle of the hallway. V1 stated the housekeeping cart should not be left in the middle of a resident hallway. V1 stated staff should have re-directed R2 away from the cart which would have avoided the fall to begin with. V1 stated R2 is unsteady on his feet at times. V1 stated R2 has been on continual observations when R2 is up and walking since 3/11/24. V1 stated "There is no reason for (R2) to have fallen like that. The staff should have been watching more closely and redirected him prior to getting that close to the housekeeping cart." V1 stated R2's fall on 4/22/24 could have been avoided if the staff were paying closer attention to R2.

The facility policy titled 'Fall Prevention' revised 11/10/18 documents Appropriate interventions will be implemented for residents determined to be at high risk at the time of admission for up to 72 hours. The unit nurse will place documentation of the circumstances of a fall in the nurses notes or on an Assess/Intercommunicate/Manage (AIM) for Wellness form along with any new intervention deemed to be appropriate at the time. Report all falls during the morning Quality Assurance

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 05/03/2024

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
S9999	Continued From page 17 meetings Monday through Friday. All falls will be discussed in the Morning Quality Assurance meeting and any new interventions will be written on the care plan. All staff must observe residents for safety. If residents with a high risk code are observed up or getting up. Help must be summoned or assistance must be provide to the resident. (B)	S9999		