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 12/04/2024

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 Investigation 2469589/IL181405	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 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. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in 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 12/04/2024

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's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

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 regulations were not met as evidenced by:

Based on observation, interview, and record review the facility failed to use proper equipment to transport a resident (R1) resulting in R1 sustaining an impacted tibia fracture and associated proximal fibula fracture. The facility also failed to follow its incident/accident policy 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 12/04/2024

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		

failing to report a serious injury to the state survey agency and thoroughly investigate an injury to determine the root cause and develop interventions for one (R1) of three residents reviewed for accidents in the sample list of seven.

Findings include:

On 12/3/24 at 1:56 PM R1 stated on 10/20/24 R1 had a left leg tibia/fibula fracture caused while V9 Certified Nursing Assistant (CNA) was pushing R1 in a shower chair down the hallway, R1 started to slip and attempted to push herself back up and R1's left toe/foot caught on the rug in the hallway. R1 screamed "ow" and thought it was broken. R1 stated x-rays were not taken for two to three days. R1 stated R1 was seen by V15 Orthopedic Physician on 11/6/24, who told R1 that R1's leg could not be casted as it would worsen R1's foot drop and require amputation, so the bones were left to fuse.

On 12/4/24 at 9:24 AM the shower chair was viewed with V7 CNA. The chair was made of plastic piping and had four small caster wheels, and it did not include foot pedals or foot/leg support.

R1's Diagnosis List documents R1 has a diagnosis of Multiple Sclerosis and is wheelchair bound. R1's Minimum Data Set dated 11/12/24 documents R1 is cognitively intact, has impaired range of motion to both legs, uses a wheelchair for mobility, and is dependent on staff for transfers.

R1's Nursing Note dated 10/21/2024 at 12:35 AM documents R1 received a shower and complained of ankle and knee pain, physician notified and orders received for x-ray. 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 12/04/2024

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	S9999		

Incident Investigation Form dated 10/21/24 at 12:30 AM, recorded by V9 CNA, documents V9 was pushing R1 in a shower chair down the hallway after R1's shower when R1's left foot was low to the ground and struck the edge of the carpet rug in front of the patio door. This form documents R1 screamed "ow" and V9 backed up to assist in moving R1's foot, R1 was brought to her room and the nurse was notified. The Incident Investigation Form dated 10/21/24 at 12:30 AM, recorded by V17 CNA, documents V17 witnessed V9 pushing R1 in a shower chair, R1 yelled "ow" and R1's toe was stuck underneath the carpet.

R1's left ankle x-ray dated 10/21/24 documents a questionable hairline fracture of the anterior aspect of the left distal tibial metaphysis and recommends additional radiographs for further evaluation. R1's left ankle x-ray dated 10/22/24 documents R1 has diffuse Osteopenia (decreased bone mineral density) and a subacute nondisplaced fracture of the distal end of the left tibia.

R1's Progress Note dated 11/6/24, recorded by V15, documents R1's chief complaint as "I (R1) slipped, caught the rug, and it rebroke my (R1's) ankle and hyperextended my (R1's) knee". This note documents based on x-rays completed on 11/6/24 R1 had an impacted left distal tibia fracture with an associated proximal fibula fracture; and R1 is nonambulatory/bed-bound and has contractures to both ankles. This note documents due to R1's significant contractures V15 did not recommend casting and recommended to repeat x-rays of the left leg to ensure that there are no changes in alignment.

R1's Care Plan with revised date 12/3/24 does not document R1's injury. There is no

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 12/04/2024

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	S9999		

documentation that the facility reported R1's incident and fracture to the state survey agency or conducted a thorough investigation to identify root cause and develop/implement interventions to address the incident.

On 12/3/24 at 3:32 PM V17 CNA stated V17 witnessed V9 CNA pushing R1 in a shower chair down the hall, R1's toe stubbed against the rug in front of the patio door and R1 yelled "Ow". V17 stated R1 was transferred to bed and complained of left shin and ankle pain which was reported to the nurse. V17 stated a lot of times residents' feet brush against the floor when staff use the shower chair to transport residents. V17 stated the staff use the shower chair to transport because there is not enough room in the shower room for the full mechanical lift and R1 uses the mechanical lift for transfers. On 12/4/24 at 9:35 AM V17 described the shower chair used for R1, and it was not a reclining back shower chair and did not have foot rest/support. V17 stated R1's incident happened on 10/20/24 around 10:00 PM.

On 12/3/24 at 4:16 PM V1 Administrator stated V1 did not report R1's injury since she did not become aware of the fracture until about a week after the incident happened. V1 confirmed R1's injury should have been reported to the state survey agency and the facility should have investigated the injury/incident. V1 stated V1 obtained staff statements regarding the incident, and staff were educated to slow down when transporting residents in a shower chair and ensure the resident's feet are off of the floor. V1 stated V1 was told by staff that R1's toe got caught on the rug while staff were pushing R1 in the shower chair down the hallway.

On 12/4/24 at 9:10 AM V2 Director or Nursing

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 12/04/2024

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 5	S9999		

stated V2 updates the care plans and confirmed R1's care plan does not address R1's injury. V2 stated V2 did not investigate R1's injury/incident and stated V2 thought it was acceptable for staff to use shower chairs to transport residents.

On 12/4/24 at 1:31 PM V16 (R1's Physician) stated V16 ordered R1's x-rays, V16 saw R1 on 10/31/24 and R1 reported R1's foot got caught and hyperextended her leg while coming back from the shower. V16 confirmed R1's fractures would be consistent with an injury caused from stubbing her toe/foot on the carpet while being transported in a shower chair. V16 stated it would have been safer to use a wheelchair to transfer between locations rather than a shower chair since there is no foot support or pedals, which a wheelchair has.

The Owner's Manual for (shower chair), provided by the facility on 12/4/24, dated November 2018 documents "This device is NOT intended to be used as a transfer bench or device."

The facility's Incident and Accidents policy dated October 2024 documents an incident/accident report will be completed for all serious accidents/incidents of residents and unexpected events that cause actual or potential harm to a resident and will include the date/time of the incident/accident, written statements, possible cause of incident, physical assessment, injuries, vital signs, treatment, and notification of appropriate parties. This policy documents to report actual injuries to the state survey agency within 24 hours of the occurrence and submit a narrative summary of the incident within five working days.

(B)

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 12/04/2024

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