FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ **B. WING** IL6009765 07/13/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 715 EAST RAYMOND ROAD WATSEKAREHAB & HLTH CARE CTR WATSEKA, IL 60970 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S 0001 **Initial Comments** S 000 Complaint 2164565/IL135477 S9999 Final Observations S9999 Statement of Licensure Violation: 300.610a) 300.1010h) 300.1210b)4) 300.1210d)3) 300.1220b)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. 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health. safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five Attachment A percent or more within a period of 30 days. The Statement of Licensure Violations facility shall obtain and record the physician's plan

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: ___ COMPLETED IL6009765 B. WING 07/13/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 715 EAST RAYMOND ROAD **WATSEKAREHAB & HLTH CARE CTR** WATSEKA, IL 60970 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY)** S9999 Continued From page 1 S9999 of care for the care or treatment of such accident. injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care 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: All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe. dress, and groom; transfer and ambulate; toilet: eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming and personal hygiene. 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: 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

Illinois Department of Public Health

made by nursing staff and recorded in the

resident's medical record.

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING_ IL6009765 07/13/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 715 EAST RAYMOND ROAD WATSEKAREHAB & HLTH CARE CTR WATSEKA, IL 60970

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(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							
546	Section 300.1220 Supervision of Nursing Services								
ž.	 b) The DON shall supervise and oversee the nursing services of the facility, including: 								
22	2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.								
	Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)								
	These requirements were not met as evidenced by:			¥3					
	Based on observation, interview and record review, the facility failed to assess and report a change of condition to the physician and family for one of three residents (R6) reviewed for improper nursing on the sample list of 22. This failure resulted in R6 becoming verbally unresponsive and being admitted to the hospital with diagnoses of Hypernatremia, with a Critical Sodium Level, Hypokalemia, and Urinary Tract Infection.			26. 1					
	Findings Include:		ia i						
	The facility Notification of Change in Resident Condition or Status Policy dated 12/7/2017 documents, the facility shall promptly notify								

Illinois Department of Public Health

PRINTED: 08/31/2021 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING IL6009765 07/13/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 715 EAST RAYMOND ROAD WATSEKAREHAB & HLTH CARE CTR WATSEKA, IL 60970 SUMMARY STATEMENT OF DEFICIENCIES (X4)ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY)** S9999 Continued From page 3 S9999 appropriate individuals (Administrator, DON (Director of Nursing), Physician, Guardian, Power of Attorney, etc) of changes in the resident's medical/mental condition and/or status. The Charge Nurse or Nursing Supervisor will notify the resident's attending physician or on-call physician when there has been a significant change in the resident's physical/emotional/mental condition, a need to alter the resident's medical treatment significantly, a need to transfer the resident to a hospital/treatment center, or any symptoms of an infectious process. On 7/7/21 at 12:23 pm, R6 was sitting up in the Dining Room .. R6 was not verbally responsive. R6's MDS (Minimum Data Set) dated 6/15/21 documents R6 has severe cognitive impairment but has clear speech and is able to make R6's needs known and is able to understand others. On 7/7/21 at 1:10 pm, V4, Agency CNA (Certified Nursing Assistant) and V5, CNA entered R6's room. V4 and V5 provided transfer instructions/request to R6 and R6 did not respond verbally or physically. V4 and V5 repeated instructions several times and R6 still did not respond. V4 and V5 transferred R6 from the wheelchair to the bed, and R6 still did not respond verbally or physically. At this point, V4

Illinois Department of Public Health

stated, "this isn't like (R6), I (V4) don't know what is going on with (R6). Normally (R6) will talk to you. (R6) is able to follow some instruction." V5

R6's Progress Notes dated 7/7/21 does not document R6's change in mental status and does not document that V16, Physician or V21, R6's Family was notified of the change in condition.

agreed with V4's statement.

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(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009765			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		B, WING			C 07/13/2021		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
WATSEK	KAREHAB & HLTH CA	ARCE LLING	RAYMOND A, IL 60970	ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG			(X5) COMPLETE DATE	
S9999	Continued From pa	ge 4	S9999			- 44	
*	later) at 8:30 am by documents R6's blo and that R6 "appea back verbally to que Monitoring according documents there has previous assessmenotified, and orders ER (Emergency Ro R6's Hospital History documents R6 was Hyperglycemia and Hypokalemia, and the R6's Laboratory Val	ry and Physical dated 7/10/21 sent to the hospital for found to have Hypernatremia, JTI (Urinary Tract Infection).					
	range of 135-145 Potassium Level of of 3.5-5.5 BUN (Blood Urea N with a normal range Creatine Level of 2. of 0.70-1.50 Glucose Level of 43 of 70-110 R6's Urinalysis date 7/11/21 documents Escherichia Coli in I R6's Discharge Sun documents R6's Hy with Intravenous Hy UTI is still being tree	8 (Critical High) with a normal 3.4 (Low) with a normal range litrogen) Level of 37 (High) of 8-25 16 (High) with a normal range 32 (High) with a normal range 32 (High) with a normal range 32 (High) with a normal range 33 (High) with a normal range 34 7/9/21 and resulted on greater than 100,000 R6's urine. Inmary dated 7/12/21 pernatremia was resolved potonic fluids and that R6's ated with an oral ABT in Intravenous ABT which R6					

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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
			A. BUILDING:		l			
IL6009765		B. WING		C 07/13/2021				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
WATSEKAREHAB & 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 APPROPRIAT DEFICIENCY)		(X5) COMPLETE DATE		
S9999	Continued From page 5		\$9999					
				<u> ,a</u>	39			
	R6's nurse on 7/7/2 a change of condition stated on 7/9/21, Volume and not responding blood glucose level V18 gave the order reassessed R6 seveno change (improve notified V16, Physical processes).	am, V18, RN stated V18 was 1 and that staff did not report on to V18 on 7/7/21. V18 18 noticed R6 was lethargic as usual and had a "high" when checked. V18 stated ed medication but when V18 eral hours later and there was ement in condition}, V18 tian and R6 was sent to the d, "that was the first! knew of		\$1 \$1				
	any change of cond	lition" with R6.						
	V16 was first notified decrease LOC (Levhigh blood glucose when notified, V16		2 2 E	s.				
	facility, or if they tru condition, we could because they are al R6 was sent to the	er do blood work there at the ly felt (R6) had a change in send (R6) to the hospital ble to do things more quickly." ER. V16 stated "with a Critical level, (R6) was dehydrated."		×	:	5 GA		
	R6 has Alzheimer's, enough, so R6 isn't also stated, with hig urinating more, whic 'The facility really no (R6) better due to (I	and R6 doesn't drink able to hydrate R6's self. V16 h blood sugars, R6 will be ch will cause dehydration. eeds to observe and monitor R6's) mental status and (R6)	*:		5-0			
	NA level is the caus (non-verbal) and the	that" for R6's self. "The high e of the mental change e elevated BUN and Creatine I (V16) should have been						
36	notified sooner and managed (R6) bette labs {laboratory test (Intravenous) fluids	we {facility} could have er, I (V16) could have ordered es} and started {R6} on IV at the facility, before it got to ent out to the hospital." V16	D E					

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ C B. WING IL6009765 07/13/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 715 EAST RAYMOND ROAD WATSEKA REHAB & HLTH CARE CTR WATSEKA, IL 60970 (X4) ID PREFIX **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY)** S9999 Continued From page 6 S9999 stated V16 always tell the nurses "if they {nurses} feel something is wrong, do not hesitate to call me (V16)." If they had called sooner with the change, further issues could have been prevented with prompt treatment. (B)

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