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 _____	R-C 02/22/2024

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

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S 000	Initial Comments First revisit to Complaint Survey: 2460938/IL169429	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6 300.2420j) 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		

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S9999	Continued From page 1 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. Section 300.2420 Equipment and Supplies j) There shall be a sufficient quantity of resident care equipment of satisfactory design and in good condition to carry out established resident care procedures. This shall include at a minimum the following: wheelchairs with brakes, walkers, metal bedside rails, bedpans, urinals, emesis basins, wash basins, footstools, metal commodes, over the lap tables, foot cradles, footboards, under the mattress bed boards, trapeze frames, transfer boards, parallel bars and reciprocal pulleys. These Requirements were NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to identify a resident's fall risk by inaccurately completing the admission Fall Risk Assessment, develop an at risk care plan for falls, implement fall prevention interventions, and ensure wheelchair brakes were functioning appropriately prior to allowing use of the wheelchair for one of three residents (R103) reviewed for falls on the sample list of eight. This	S9999		

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S9999	Continued From page 2	S9999		

failure resulted in R103 falling while transferring R103's self from the wheelchair to the bed and sustaining a fractured pelvis.

Findings Include:

The facility's Fall Investigation Folder for R103 contains a Smartsheet Form dated 2/19/24 at 8:41 am that documents, R103 self transferred, fell, and sustain pelvic fracture This folder also contains a Final Report to IDPH (Illinois Department of Public Health) that documents on 2/16/24 at 8:00 am, R103 stated R103 locked the brakes on R103's wheelchair, then attempted to self transfer from the wheelchair to the bed but the wheelchair moved backwards. R103 then fell to the floor on R103's bottom, hitting R103's BKA-R (Right Below the Knee Amputation) in the process. R103's BKA-R was bleeding from the incision site so R103 was sent to the ER (Emergency Room) for evaluation and treatment. R103 was diagnosed with a "bilateral pelvic fracture" and returned to the facility with orders to follow up with orthopedic and primary doctors related to the bilateral pelvic fracture.

R103's Medical Imagining Report dated 2/16/24 documents R103 fell from a wheelchair and has a recent amputation of the right lower leg. The pelvis is notable in that there is suggestion of irregular appearance of the right inferior pubic ramus and left inferior pubic ramus is seen and could indicate fractures of the inferior pubic rami.

R103's Hospital Discharge Summary dated 2/16/24 documents, " closed stable fracture of multiple pubic rami".

R103's ongoing Census documents R103 admitted to the facility on 2/15/24.

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R103's ongoing Diagnosis Listing documents the following: Complete Traumatic Amputation at Knee Level/Right Lower Leg, Morbid Obesity, Visual Loss of Right Eye, Diabetes, Peripheral Neuropathy, Anxiety, and Bipolar.

R103's Fall Risk Assessment dated 2/15/24 documents R103 is not a fall risk and documents R103 is ambulatory with no gait/balance problems, has not had any medication changes in last five days and does not take any high risk medications that would increase R103's risk for falls.

R103's February 2024 Physician Orders document R103 is ordered the following "high risk" medications: Oxycodone {Opiate/Narcotic} 5 mg (milligrams) every 6 hours PRN (as needed), Citalopram {Antidepressant} 20 mg daily, Depakote Delayed Release {Anticonvulsant used for treatment in Bipolar} 500 mg every night, Diazepam {Benzodiazepine} 5 mg BID (twice a day), and Buspirone {Anxiolytic} 10 mg TID (three times a day).

R103 did not have a baseline careplan that identified R103's fall risk.

On 2/21/24 at 10:40 am, R103 was sitting up in a wheelchair in R103's room. R103's right lower leg is amputated. R103 stated R103 had a fall while transferring R103's self into bed and now has multiple pelvic fracture because of it. R103 explained R103 had locked and even double checked the brakes of the wheelchair, stood up and the chair moved backwards causing R103 to fall onto R103's buttocks. R103 demonstrated how the wheelchair continues to roll even though the brakes are on by pushing down on the brakes

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S9999	Continued From page 4	S9999		

as hard as R103 could, twice, then pushing on the ground with R103's foot and the wheelchair rolled backwards. R103 stated R103 knows how to transfer R103's self because after R103's amputation, R103 remained in the hospital for two weeks and received therapy. R103 explained R103 only came to the facility for an additional couple of weeks to gain strength, prior to going home after the amputation . R103 stated since falling and fracturing R103's pelvis, R103 is having "horrible pain" and just can't get comfortable, is only getting about three hours a sleep a night and now the facility is wanting R103 to call for assistance for transfers. R103 started to cry and R103's voice started to crack. R103 stated, "I just can't do that. With now having multiple rami fractures and with my pain in my pelvis; it's horrible!" R103 explained R103 can't get comfortable in the wheelchair or in the bed and because of that, "it is making my mental health worse, which I don't need because I'm already bipolar, have anxiety and depression". R103 stated the Oxycodone is a new medication that was recently started after R103's amputation because the Norco wasn't helping R103 anymore.

On 2/21/24 at 11:07 am, V7, Maintenance Director stated V7 checks one or two wheelchairs a day for proper functioning but did not check R103's before giving it to R103 or since R103's fall. V7 stated V7 hasn't been told there is anything wrong with it. At this time, V7 locked R103's wheelchair brakes, with R103 in the wheelchair and attempted to move the wheelchair. The wheelchair did roll/slide, even though the brakes were engaged, which V7 confirmed.

On 2/21/24 at 11:34 am, V2 AIT with V10 CNA (Certified Nursing Assistant) and V7 present

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S9999	Continued From page 5 stated that V2 and V10 both checked R103's wheelchair brakes after R103 fell and went to the hospital, and they were fine, therefore R103's concern of the brakes not working was not reported to V7. At this time, V7 stated, "the brakes would grab better without a resident in it." On 2/21/24 at 12:33 pm, V2 stated R103 is a high fall risk and confirmed R103's Fall Risk Assessment is not accurate due to R103 being a "new amputee", not being ambulatory, not have a steady gait and being on "all kinds of medications that trigger on the assessment". V2 also confirmed R103 did not have a fall risk care plan with fall prevention interventions in place until after R103 fell. The facility's Fall Prevention Policy dated 11/10/18 documents the facility will provide for resident safety and minimize injuries related to falls; decrease falls and still honor each resident's wishes/desires for maximum independence and mobility. A fall assessment should be completed on the day of admission and appropriate interventions will be implemented for resident's determined to be at high risk at the time of admission for up to 72 hours. "A"	S9999		