STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145389	A. Building B. Wing	12/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Watseka Rehab & Hlth Care Ctr	715 East Raymond Road Watseka, IL 60970

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on observation, interview and record review the facility failed to ensure R4 was not subject to verbal/mental abuse bystaff. R4 is one of five residents reviewed for abuse on the sample list of 33. Findings Include: R4's Physician Order Sheet dated 12/01/21- 12/31/21 documents the following diagnoses: Frontal Temporal Dementia with Behavioral Disturbance, Anxiety, Agitation, Schizoaffective Disorder and Depression. R4's Minimum Data Set (MDS) dated [DATE] documents the following: R4 cognitive status is severely impaired. The same MDS documents R4 has not had any rejection of care, physical or verbal behaviors toward others or himself, and has not had any hallucinations or delusions. R4's Care Plan dated 9/10/21 documents the following: Problem/Need (Private) Hospice Services chosen; to provide psychosocial support, related to End Stage Diagnosis of Alzheimer. I am wanting to focus on comfort more than aggressive treatment. Approach/ Interventions (initiated 4/9/21): Talk in a calm, soft tone, make eye contact, use non-threatening body language. On 12/9/21 at 12:50 pm, when entering the locked memory care unit, a loud voice was coming from R4's room. V26, Certified Nursing Assistant (CNA) yelled Don't you hit me. Approaching R4's doorway, V26, (large in stature) CNA was standing in front of R4 (small in stature), in the middle of R4's bedroom. R4 was facing the doorway at an angle and V26, CNA was looking down into R4's face. V26's face was positoned within three inches of R4's nose. V26, CNA had both of her hands on V26's waist and was leaning toward R4 in a threatening manner. V26, CNA continued with the same threatening stance and yelled twice in rapid sequence Don't you hit me, don't you hit me directly into R4's face. R4 stood completely still with a flat affect and did not respond verbally or physically to V26's threatening approach. On 12/9/21 at 12:53 pm V26, CNA stated That is just how I stand. I always have my hands on my side. (V26's did not have V26's hands on V26's waist at the onset of the interview. V26, CNA brought her arms up and placed V26's hands on her waist to demonstrate at this time). I guess being that close to his (R4's) face is intimidating, but he hit me.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Potential for minimal harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on record review and interview, the facility failed to operationalize their abuse prevention policy by failing to prevent staff to resident verbal abuse and failed to immediately report an allegation of staff to resident alleged verbal abuse to the administrator. These failures have the potential to affect all 56 residents residing in the facility. Findings include: 1. On 12/9/21 at 12:50 pm, when entering the locked memory care unit, a loud voice was coming from R4's room. V26, Certified Nursing Assistant (CNA) yelled Don't you hit me. Approaching R4's doorway, V26, (large in stature) CNA was standing in front of R4 (small in stature), in the middle of R4's bedroom. R4 was facing the doorway at an angle and V26, CNA was looking down into R4's face. V26's face was positioned within three inches of R4's nose. V26, CNA had both of her hands on V26's waist and was leaning toward R4 in a threatening manner. V26, CNA continued with the same threatening stance and yelled twice in rapid sequence Don't you hit me, don't you hit me directly into R4's face. R4 stood completely still with a flat affect and did not respond verbally or physically to V26's threatening approach. 2. On 12/7/21 at 2:00 pm V6 Activity Director submitted Resident Council Minutes for October 13, 2021 The resident council meeting minutes document a resident complaint as follows: Dietary worker (V12, Cook) saying mean abusive things to a resident (R6,) when asking for different meal request. V6 also stated she did not report the allegation of verbal abuse until 10/14/21. On 12/14/21 at 3:20 pm, V7, Social Service Director/Acting Assistant Administrator/Abuse Coordinator stated We have to go by our abuse (prevention) policy to make sure our residents are treated right. We didn't do that therefore (V20, [NAME] President of Business Development/ Acting Administrator) reeducated (V26, Certified Nursing Assistant/CNA). We did not follow our abuse policy when (V6, Activity Director) failed to report the incident (verbal abuse allegation) between (V12, Cook) and (R6) to (V1, Administrator/Abuse Prevention Coordinator). (V6, Activity Director) has been reeducated to report immediately. (continued on next page)

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F 0607 Level of Harm - Potential for minimal harm Residents Affected - Many	The facility policy titled Abuse Prevention Program dated January 2020 directs facility staff on the following: This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined below. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This facility therefore prohibits mistreatment, exploitation, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, exploitation, neglect or abuse of our residents. This will be done by: * Conducting required pre-employment screening of employees; * Orienting and training employees on how to deal with stress & difficult situations, and how to recognize & report occurrences of mistreatment, exploitation, neglect, and abuse immediately to supervisory personnel;* Training on activities that constitute abuse, neglect, exploitation and misappropriation of resident property.* Establishing an environment that promotes resident sensitivity, resident security and prevention of mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property; including, prohibiting staff from using any type of equipment (e.g., cameras, smart phones, and other electronic devices) to keep, or distribute photographs and recordings of residents that are demeaning or humiliating.* Identifying occurrences and patterns of potential mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property;* Dementia management and resident abuse prevention.* Immediately protecting residents involved in identified reports of possible abuse;* Implementing systems to investigate all reports and allegations of mistreatment, exploitation, neglect, abuse of residents and misappropriation of resident property; promptly and aggressively, and making the necessary changes to prevent future occurrences; and* Procedures for reporting of potential incidents of abuse, neglect, exploitation or the misappropriation of resident property. This facility is committed to protecting our residents from abuse by anyone including; but not limited to, facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals. This facility will not knowingly employ or otherwise engage individuals who have had a disciplinary action taken against a professional license by a state licensure body as a result of a finding of abuse, neglect, or mistreatment of residents or a finding of misappropriation of resident property. (continued on next page)

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F 0607 Level of Harm - Potential for minimal harm Residents Affected - Many	Definitions: The following definitions are based on federal and state laws, regulations and interpretive guidelines. * Abuse: Abuse is the willful injection of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. * Adverse Event: An adverse event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof * Exploitation means taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion. * Physical Abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment.* Sexual Abuse is non-consensual sexual contact of any type with a resident.* Verbal Abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, threats of [NAME], or saying things to frighten a resident, such as telling a resident that he/she will never to be able to see his/her family again.* Mental Abuse includes, but is not limited to, abuse that is facilitated or caused by nursing home staff taking or using photographs or recordings in any manner that would demean or humiliate a resident(s), harassment, humiliation and threats of punishment or deprivation.* Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.* Mistreatment means inappropriate treatment or exploitation of a resident.* Involuntary Seclusion means separation of a resident from other residents or from his/her room - or confinement to his/her room against the resident's will or the will of the resident's legal guardian. Emergency or short term monitored separation from other residents is not considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention to reduce agitation in accordance with existing care plan interventions or until staff can develop a plan of care to meet the resident's needs. In addition, if the purpose of the resident living in a unit which prevents residents from free movement throughout the facility is to provide specialized care for residents who are cognitively impaired, then placement in the unit is not considered involuntary seclusion, as long as care and services are provided in accordance with each resident's individual needs and preferences rather than for staff convenience, and as long as the resident, surrogate, or representative participates in the placement decision and is involved in continuing care planning to assure placement continues to meet resident needs and preferences. * Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. * Serious Bodily Injury: an injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or requiring medical intervention such as surgery, hospitalization , or physical rehabilitation; (continued on next page)

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F 0607 Level of Harm - Potential for minimal harm Residents Affected - Many	Procedures for Prevention: I. Pre-Employment Screening of Potential Employees: This facility will not knowingly employ or otherwise engage individuals who have had a disciplinary action taken against a professional license by a state licensure body as a result of a finding of abuse, neglect, or mistreatment of residents or a finding of misappropriation of resident property. The facility will not knowingly employ any staff convicted of any of the crimes listed in the Illinois Healthcare Worker Background Check Act (unless waivered under the provision of the Act), or with findings of abuse listed on the Illinois Health Care Worker Registry. Prior to a new employee starting a work schedule this facility will:* Initiate a reference check from previous employer(s)* Obtain a copy of the state license of any individual being hired for a position requiring a professional license and check the licensee's status with the licensing entity.* Check the Illinois Health Care Worker Registry on all individuals being hired for a position and potentially bordering states that the individual is known to have been licensed/certified in, based on the individuals resume or other employment information available to the facility; and * Under the Health Care Worker Background Check Act (225 ILCS 46/1) and facility Criminal Background Check Policy'' policy, we are required to request a fingerprint based criminal history records check for all non licensed employees. It is the facility policy that we request a non fingerprint based criminal history record check for all licensed employees. The same policy Abuse Prevention Program documents the following: IV. Internal Reporting Requirements and Identification of Allegations Employees are required to immediately report any occurrences of potential/alleged mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property they observe, hear about, or suspect to a supervisor and the administrator. All residents, visitors, volunteers, family members or others are encouraged to report their concerns or suspected incidents of potential/alleged mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property to a supervisor and administrator. Such reports may be made without fear of retaliation. Anonymous reports will also be thoroughly investigated. Supervisors shall immediately inform the administrator or his/her designated representative (specified by the administrator in the case of a planned absence) of all reports of potential/alleged mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property. Upon learning of the report, the administrator or designee shall initiate an investigation. The nursing staff is additionally responsible for reporting on a facility incident report the appearance of bruises, lacerations, other abnormalities, or injuries of unknown origin as they occur. Upon report of such occurrences, the nursing supervisor is responsible for assessing the resident, reviewing the documentation and reporting to the administrator or designee. If the resident complains of physical injuries or if resident harm is suspected, the resident physician will be contacted for further instructions. The facility Nursing Midnight Census dated 12/6/21 documents 56 residents reside in the facility.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 31642 Based on record review and interview, the facility failed to ensure that staff report an allegation of verbal abuse, immediately to the administrator. This failure affected one of five residents (R6) reviewed for abuse on the sample list of 33. Findings include: On 12/7/21 at 2:00 pm V6 Activity Director submitted Resident Council Minutes for October 13, 2021 The resident council meeting minutes document a resident complaint as follows: Dietary worker (V12, Cook) saying mean abusive things to a resident (R6,) when asking for different meal request. V6, Activity Director stated V6 is new to the facility and did not know to report an abuse allegation to the administrator. V6 stated I (V6) was not sure who was in charge. V6 also stated I reported the incident to (V7, Social Service Director) the next day (October 14, 2021), in morning meeting. A kitchen (V12, Cook) staff member yelled curse words, threatened to hit and stab a resident (R6) for asking for substitute meal. V6 then stated The (V5) Business Office Manager, (V21) Housekeeping Supervisor and (V4) Previous Director of Nursing were in the meeting (10/14/21) too. On 12/8/21 at 3:55 pm, R6 stated (V12, Cook) said 'If I had a knife I would use it'. (V12, Cook) does not say that to anybody else. Other residents get the food they want right off. Me (R6) and my brother (R33) share a room and get diarrhea from greasy food. When I ask (V12, Cook) for a sandwich instead of the meal, she always gives me a hard time. R6 then stated You are not going to find any other resident or staff member that has heard the way (V12, Cook) talks to me. (V12, Cook) makes sure nobody is around when she yells and tells me to get the (expletive) out of there. On 12/7/21 at 3:25 pm V7, Social Service Director / Acting Assistant Administrator/Abuse Coordinator stated I was in the daily meeting when (V6, Activity Director) reported the incident. (V6, Activity Director) should have reported this allegation immediately (10/13/21) to a supervisor, who then would start an abuse investigation immediately. (V4, previous Director of Nursing /DON) and I initiated the investigation immediately after the morning meeting (10/14/21) and did interview (R6). I assume she (V4, previous DON) reported to IDPH (Illinois Department of Public Health). (V4, DON) does not work here any longer and I will have to go through her office. (V1, Administrator/Abuse Coordinator) was sick and I believe this was reported to (V3, Regional RN/ LNHA). V7 also stated It is our (abuse prevention) policy to report abuse allegations to administrator immediately and should be followed to the T.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on record review, observation and interview the facility failed to provide staff supervision for two of four residents (R4 and R5) reviewed for falls/safety/supervision on the sample list of 33. This failure resulted in R4 and R5 falls, both sustaining head lacerations that required emergency treatment with staples. Findings include: The facility policy Fall Prevention dated as revised 11/10/18 documents the following: Policy: To provide for resident safety and to minimize injuries related to falls; decrease falls and still honor each resident's wishes /desires for maximum independence and mobility. Responsibility: All staff. Procedure: 1. Conduct fall assessments on the day of admission, quarterly, and with a change in condition. 2. Identify, on admission, the resident's risk for falls. A visual prompt may be placed on the name plaque by the entrance to the resident's room. If used, any Assistive device such as walker or cane will be identified with the same visual prompt to match the prompt at the entrance to the room. This system provides staff a visual alert to monitor those at risk for falls. (Blank) indicated high risk for falls. The facility should signify what the visual prompt will be and if none is used signify N/A (not applicable). All staff must observe residents for safety. If a resident is a high risk code are observed up or getting up, help must be summoned or assistance be provided to the resident. 1) R4's Physician Order Sheet dated 12/01/21- 21/31/21 documents the following diagnoses: Frontal Temporal Dementia with Behavioral Disturbance, Anxiety, Agitation, Schizoaffective Disorder and Depression. R4's Care Plan dated 9/10/21 documents the following: Problem/Need, Plan, Resident has risk factors that require monitoring and interventions to reduce potential for self-injury. Risk factors include Dementia as evidence by poor safety awareness has related diagnosis/condition/history includes Dementia. Goal, Resident will follow safety suggestions and limitations with supervision and verbal reminders for better control of risk factors through next 90 days. Approach, Keep call light within reach at all times, Answer promptly and notify resident that help is on the way. R4's Minimum Data Set (MDS) dated [DATE] documents the following: R4 cognitive status is severely impaired. The same MDS documents R4 requires staff assistance physical staff assistance with transfers, and to stabilize when transitioning surface to surface and moving from seated to standing position. On 12/8/21 at 5:20 am, V16, Certified Nursing Assistant (CNA) ambulated R4 to the bathroom. R4 had a two-inch laceration to his head. V16, CNA stated R4 had a fall a couple weeks ago got a head laceration that required staples. R4's Fall Risk assessment dated [DATE] documents R4 is at high risk for falls = high risk if greater than 10 points. R4's scored is documented as 14 (high risk). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R4's Nurse Progress Note dated 11/3/21 at 3:30 am documents R4 was found on the floor with blood on his head. R4's A.I.M. (Assess, Intercommunicate Manage) Wellness Fall Note dated 11/03/21 documents an (unidentified) Physician was notified at 3:30 am and gave orders to: Apply pressure to (R4's) head/send to ER (emergency room), (Private) Memorial Hospital/(Private) Hospice notification. R4's Nurse Progress Note dated 11/3/21 at 5:30 am documents R4 received 10 staples to his head. R4 Nurse Progress Note dated 11/3/21 at 6:30 am documents R4 returned to the facility via ambulance. R4's Hospital Discharge Instruction dated 11/3/21 documents the following Diagnosis: Scalp Laceration Discharge Instructions: Keep wound clean and dry. The staples (number not identified) can be removed after seven days. 2) R5's Physician Order Sheet dated 12/1/21 documents the following diagnoses: Depression, Insomnia Related to Anxiety. R5's Care Plan dated 10/12/21 documents the following: Problem/Need, Plan, Has risk factors for falls: Balance, Assistive devices, Needs assistance with transfers. Medical condition, Meds (medication) , Poor safety awareness, Vision problems, and Behaviors put resident at risk. Goal, Will have no falls through admission and care plan review. Approach: Assess cognitive deficits and accommodate forgetfulness regarding safety and environmental hazards. Observe for behaviors that put that place resident at risk for injury. R5's Minimum Data Set (MDS) dated [DATE] documents the following: R5 has a Brief Interview of Mental Status (BIMS) score of six out of 15, severe cognitive impairment. The same MDS documents R5 requires physical staff assistance with transfers, and to stabilize when transitioning surface to surface and moving from seated to standing position. On 12/8/21 at 5:00 am, R5 had one staple on a laceration at the back of R5's head. R5 stated I fell and hit my head, but I can't remember where I was, or if anybody was with me. I think my sister helped me up. R5's Fall Risk assessment dated [DATE] documents R5 is at high risk for falls = high risk if greater than 10 points. R5's score is documented as 17. R5's Nurse Progress Note dated 12/5/21 at 7:50 pm documents R5 was found on the floor in supine position and was positive for blood on the back of R5's head. R5's A.I.M. (Assess, Intercommunicate Manage) Wellness Fall Note dated 12/5/21 (unknown time) documents an (unidentified) Physician was notified at 7:55 pm and gave orders to: Send to (R5) ER (emergency room) at (Private) Memorial Hospital, after assessing resident and obtaining vital signs. The same A.I.M for Wellness note documents R5 had head pain with the intensity of pain score rating of eight-nine out of 10 (10 being the worst pain level by scale). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R5's Nurse Progress Note dated 12/5/21 at 10:30 pm documents the following: Informed by (Private) Hospital emergency room : one staple on back of head, CT scan cleared for discharge. R5's Hospital Discharge Instruction dated 12/5/21 Diagnosis: Simple Laceration of Scalp. Discharge Instructions: Staple to be removed after seven days. On 12/8/21 at 4:00 am V14, Registered Nurse (RN) stated the following: What happen with (R4) was, I was watching call lights and getting medication pass set up outside B-Hall (Memory Care Unit), while (V9, previous Certified Nursing Assistant/ CNA) was doing rounds (room checks and care) on C-Hall and A-Hall. (R4) fell and we didn't know it. (R4) fell in his room and we had no idea how long he was on the floor. Neither (V9, CNA) or I (V14, RN) had been over there (B-Unit) in about an hour and a half. It takes about 45 minutes to do each A-Hall and C-Hall rounds. (V9, previous CAN) found (R4) on the floor of his room on B-Unit, after doing rounds outside the B-Unit. (R4) had a lot of blood coming from his head and blood on the floor. He was alert but has Dementia and could not say what happened. I applied pressure, got vital signs, did neuros (neurological) assessments, and sent him to the hospital. He got (treated) with at least five staples in his head and came back to the facility. V14, RN also stated the following: What happen with (R5), it was change of shift, days to evening. I was receiving report from days and passing meds (medication) outside the unit (B, locked memory care). There was no CNA on memory care after 6:30 pm end of shift until (V8, CNA) went over to B-unit and found (R5) on the floor. (V8, CNA) had been doing rounds on A-Unit and C-Unit. Around 7:45 pm Sunday (12/5/21), (V17, RN) said (V8, CNA) found (R5) on the floor. I went to B-Unit immediately. (R5) was on the floor and had a laceration to her head. I did vital signs, neuro (neurological assessment), applied pressure to the wound and sent her out (to the hospital). (R5) came back (from the emergency room) with one staple to her head. V14, RN also stated I have been complaining about staffing to (V4, previous Director of Nursing) and (V7, Social Service Director, Assistant Administrator) weekly for about three months. I complained to (V4, previous Director of Nursing and V7, SSD) that it is not safe for the residents and residents are not receiving the quality of care that they should. There are times between 6:00 pm and 8:00 pm I have no CNA (Certified Nursing Assistant) for the entire building. V14, RN also stated: When it is just me (V14, RN,) I cannot adequately provide care, answer call lights and do (administer) meds (medication). On 12/8/21 at 10:30 am V8, Certified Nursing Assistant (CNA) stated the following: I have had to work alone on evenings a couple of times (unidentified) for and hour or two until the nurse (unidentified) could get another staff member in here to work. I have had to do (full mechanical lift) transfers alone. The evening (12/5/21), (R5) fell . I did rounds on B-Unit (Memory Care locked unit) after I completed rounds on A and C units. I (V8, CNA) found (R5) in (R14's) room on the floor about 8:00 pm or 9:00 pm. (R14) was trying to get (R5) up (from the floor). I called for help and the nurse (V14, RN) came and assessed (R5) and sent her to the ER. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/8/21 at 4:20 pm V18, Physician/Medical Director stated I (V18) am not aware that one CNA (Certified Nursing Assistant) was taking care of all residents on their own. This was never reported to me. For the quality of care required for these residents, nursing staff should meet the minimum staffing requirements. I am not sure what that is for this facility. Staffing should be based on the level of care needed. Incontinence care should be provided or offered several times per shift. Several of the residents in this facility require a skilled level of care. There should always be enough staff working to maintain a safe environment. Falls do happen despite all we do to prevent them. It should never be because there was not enough staff to supervise these residents. The memory care unit (B-Unit) would require constant staff supervision due to the residents on that unit's inability to recognize safety precautions. I am aware the (R1, R4, R5, R9) have had falls in the facility. Each of those falls were reported and orders were given to send to the hospital for evaluation and treatment. Most recent, (R4 and R5) both fell resulting in lacerations to the head which required ER (emergency room)evaluation and treatment. I did not realize there was no supervision on the unit at the time of these falls. Of course those injuries could have been prevented had the (R4 and R5) not fallen. On 12/7/21 at 4:05 pm V23, Memory Care Unit Coordinator stated All residents should be supervised but the memory care unit (B-Unit) residents more so because they can not remember to put on their call light for staff assistance. (R4) fell in the last month which resulted in a laceration to (R4's) head. He had to get numerous staples in the back of his head. No one knows what really happened because there were no staff working on B-Hall (Memory Care Unit) that night. The night shift is consistently short staffed. The night CNA's (Certified Nursing Assistance) working A and C halls, outside the B unit (locked memory care) are supposed to provide the care and check on the residents. I don't know if that is happening. Frequently the day shift CNA's complain that residents are not being changed (incontinence care). There are odors of urine when I come in each morning. I am not a Nurse or CNA so I cannot provide personal care. (R5) had a fall a couple days ago which also resulted in staples to the back of her head. (R5) is not supposed to get up on her own. There was not a staff member over here (B-Unit) when (R5) fell . How long (R5) was on the floor is unknown. Staff do transfer residents by (full mechanical lift) with only one staff member because even on evenings there are not always two staff available. V23 also stated I am leaving (facility employment) in two days which is directly related to the facility not providing staff to care for the residents on B-Unit. Management (unidentified) is totally aware and have done nothing to get more staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145389	A. Building B. Wing	12/14/2021

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Watseka Rehab & Hlth Care Ctr	715 East Raymond Road 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)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 31642 Based on record review, observation and interview the facility failed to ensure staff provide timely incontinence care for four of seven residents (R4, R7, R9 and R10) reviewed for incontinence are on the sample list of 33. Findings include: 1. On 12/8/21 at 4:45 am V16, Certified Nursing Assistant (CNA) entered R9's room to provide incontinence care. R9's room had a strong foul urine odor. V16, CNA stated I (V16, CNA) was supposed to do rounds every two hours, but it is not possible with only one CNA. I do the best I can. V16, CNA stated The last time I provided incontinence care was when I did care rounds on Unit-B (Memory Care Unit) about midnight. V16, CNA lifted R9's urine-soaked, cloth linen savor beneath R9's buttocks, and over the fitted sheet, to reposition R9 to a left side lying position. R9's fitted sheet under the linen savor had a brown dried urine ring measuring approximately 18-inch diameter with an eight-inch wet yellow center on the fitted bed sheet. R9 had a leg brace that extended from her mid-calf, over her knee up to her mid-thigh. R9's leg brace was secured with a wrapped loose gauze. The top of the gauze wrap was wet with yellow urine. R9 had an intact duoderm pressure ulcer dressing on R9's coccyx. R9's buttocks was slightly red. 2. On 12/8/21 at 5:20 am V16, CNA entered R4's room. R4's room had a strong foul odor of urine. V16, CNA assisted R4 to a standing position. There was a three foot by three-foot circle at the center area of R4's fitted bed linen saturated with urine. The bottom four inches of R4's tee shirt was soaked in urine. R4's incontinence brief was completely saturated with urine and dripped onto the floor as V16,CNA guided R4 into the bathroom from his bed. V16 stated (R4) was changed (provided incontinence care) a little before midnight. I (V16, CNA)try to change (R4) first on rounds because he is a heavy wetter. R4's skin was visibly wet with urine as V16, CNA removed R4's incontinence brief in the bathroom. 3. On 12/8/21 at 5:30 am V16, CNA entered R7's room. R7's room had a strong smell of feces. V16, CNA stated the last time R7 was checked for incontinence care was when R7 was put to bed last evening around 10:00 pm. V16, CNA stated V16, CNA transferred R7 via a full mechanical lift from a chair to bed. R7 had an indwelling urinary catheter drainage bag hanging from the frame of her low bed. V16, CNA removed R7's bedspread. R7 had dried feces on her upper inner thighs, anterior and posterior upper legs below her incontinence brief, and above R7's incontinence brief on R7's low back. V16, CNA removed R7's soiled incontinence brief. R7's indwelling urinary catheter had dried feces from the urethra down the catheter approximately five inches. R7 had feces under all ten fingernails and dried feces on both hands. R7 was scratching the dried feces off of her lower pelvis with both hands. R7 had an extra-large formed bowel movement in her incontinence brief and dried feces on bilateral buttocks. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 12/8/21 at 6:10 am V15, Certified Nursing Assistant (CNA) entered R2's bedroom. R10's bedroom had a strong, foul, urine odor. V15, CNA stated the following: This is only the second time I changed (R10) since I came in at 8:00 pm last night (12/7/21). I did her (incontinence care) about 8:30 pm. It is not easy to take care of all the residents in the facility even when there is two CNA's (V16, CNA on locked B-unit and V15, CNA on A and C- Unit). I was busy answering call lights and giving care. V15, CNA pulled R10's blanket down. R10 was laying with a urine-soaked hospital gown on. The wet hospital gown was saturated from R10's chest to the bottom hem of the gown in front and upper back to the bottom hem. R10's incontinence brief was totally saturated in urine with cotton absorbent incontinent brief pieces stuck to R10's wet lower abdomen. R10's upper inner thighs were red. R10's fitted bed sheet was wet from just below R10's shoulders to her feet. On 12/7/21 at 4:05 pm V23, Memory Care Unit Coordinator stated All residents should be supervised but the memory care unit (B-Unit) residents more so because they can not remember to put on their call light for staff assistance. (R4) fell in the last month which resulted in a laceration to (R4's) head. He had to get numerous staples in the back of his head. No one knows what really happened because there were no staff working on B-Hall (Memory Care Unit) that night. The night shift is consistently short staffed. The night CNA's (Certified Nursing Assistance) working A and C halls, outside the B unit (locked memory care) are supposed to provide the care and check on the residents. I don't know if that is happening. Frequently the day shift CNA's complain that residents are not being changed (incontinence care). There are odors of urine when I come in each morning. I am not a Nurse or CNA so I cannot provide personal care. (R5) had a fall a couple days ago which also resulted in staples to the back of her head. (R5) is not supposed to get up on her own. There was not a staff member over here (B-Unit) when (R5) fell . How long (R5) was on the floor is unknown. Staff do transfer residents by (full mechanical lift) with only one staff member because even on evenings there are not always two staff available. V23 also stated I am leaving (facility employment) in two days which is directly related to the facility not providing staff to care for the residents on B Unit. Management (unidentified) is totally aware and have done nothing to get more staff. On 12/8/21 at 4:20 pm V18, Physician / Medical Director stated that incontinence care should be provided or offered several times per shift. The facility policy Preventative Skin Care dated revised January 2018 documents the following: Policy: It is the facility's policy to provide preventative skin care through repositioning and careful washing, rinsing, drying, and observation of the resident's skin condition to keep them clean, comfortable, well groomed, and free from pressure ulcers. Responsibility: All nursing staff, Procedures: 1. Staff on every shift and as necessary will provide skin care. 12. Maintain wrinkle free, clean, dry bed linen. 13. Keep incontinent residents clean and dry.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 31642 Based on observation, record review and interview the facility failed to have sufficient nursing staff to provide supervision for R4 and R5 to prevent falls with injuries, failed to provide sufficient staff to perform timely incontinence care to residents (R4, R7, R9, and R10) dependent on physical staff assistance. Findings include: 1. R4's A.I.M. (Assess, Intercommunicate Manage) Wellness Fall Note dated 11/03/21 documents an (unidentified) Physician was notified at 3:30 am and gave orders to: Apply pressure to (R4's) head/send to ER (emergency room), (Private) Memorial Hospital/(Private) Hospice notification. 2. R5's A.I.M. (Assess, Intercommunicate Manage) Wellness Fall Note dated 12/5/21 (unknown time) documents an (unidentified) Physician was notified at 7:55 pm and gave orders to: Send to (R5) ER (emergency room) at (Private) Memorial Hospital, after assessing resident and obtaining vital signs. The same A.I.M for Wellness note documents R5 had head pain with the intensity of pain score rating of eight-nine out of 10 (10 being the worst pain level by scale). 3. On 12/8/21 at 4:45 am V16, Certified Nursing Assistant (CNA) entered R9's room to provide incontinence care. R9's room had a strong foul urine odor. V16, CNA stated I (V16, CNA) was supposed to do rounds every two hours, but it is not possible with only one CNA. I do the best I can. V16, CNA stated The last time I provided incontinence care was when I did care rounds on Unit-B (Memory Care Unit) about midnight. V16, CNA lifted R9's urine-soaked, cloth linen savor beneath R9's buttocks, and over the fitted sheet, to reposition R9 to a left side lying position. R9's fitted sheet under the linen savor had a brown dried urine ring measuring approximately 18-inch diameter with an eight-inch wet yellow center on the fitted bed sheet. R9 had a leg brace that extended from her mid-calf, over her knee up to her mid-thigh. R9's leg brace was secured with a wrapped loose gauze. The top of the gauze wrap was wet with yellow urine. R9 had an intact duoderm pressure ulcer dressing on R9's coccyx. R9's buttocks was slightly red. 4. On 12/8/21 at 5:20 am V16, CNA entered R4's room. R4's room had a strong foul odor of urine. V16, CNA assisted R4 to a standing position. There was a three foot by three-foot circle at the center area of R4's fitted bed linen saturated with urine. The bottom four inches of R4's tee shirt was soaked in urine. R4's incontinence brief was completely saturated with urine and dripped onto the floor as V16,CNA guided R4 into the bathroom from his bed. V16 stated (R4) was changed (provided incontinence care) a little before midnight. I (V16, CNA)try to change (R4) first on rounds because he is a heavy wetter. R4's skin was visibly wet with urine as V16, CNA removed R4's incontinence brief in the bathroom. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On 12/8/21 at 5:30 am V16, CNA entered R7's room. R7's room had a strong smell of feces. V16, CNA stated the last time R7 was checked for incontinence care was when R7 was put to bed last evening around 10:00 pm. V16, CNA stated V16, CNA transferred R7 via a full mechanical lift from a chair to bed. R7 had an indwelling urinary catheter drainage bag hanging from the frame of her low bed. V16, CNA removed R7's bedspread. R7 had dried feces on her upper inner thighs, anterior and posterior upper legs below her incontinence brief, and above R7's incontinence brief on R7's low back. V16, CNA removed R7's soiled incontinence brief. R7's indwelling urinary catheter had dried feces from the urethra down the catheter approximately five inches. R7 had feces under all ten fingernails and dried feces on both hands. R7 was scratching the dried feces off of her lower pelvis with both hands. R7 had an extra-large formed bowel movement in her incontinence brief and dried feces on bilateral buttocks. 6. On 12/8/21 at 6:10 am V15, Certified Nursing Assistant (CNA) entered R2's bedroom. R10's bedroom had a strong, foul, urine odor. V15, CNA stated the following: This is only the second time I changed (R10) since I came in at 8:00 pm last night (12/7/21). I did her (incontinence care) about 8:30 pm. It is not easy to take care of all the residents in the facility even when there is two CNA's (V16, CNA on locked B-unit and V15, CNA on A and C- Unit). I was busy answering call lights and giving care. V15, CNA pulled R10's blanket down. R10 was laying with a urine-soaked hospital gown on. The wet hospital gown was saturated from R10's chest to the bottom hem of the gown in front and upper back to the bottom hem. R10's incontinence brief was totally saturated in urine with cotton absorbent incontinent brief pieces stuck to R10's wet lower abdomen. R10's upper inner thighs were red. R10's fitted bed sheet was wet from just below R10's shoulders to her feet. On 12/8/21 at 9:40 am V3, Registered Nurse/ Interim Administrator stated We are advertising on (Private company) website online and use agency for staffing. We are and doing interviews constantly trying to hire new CNA's, Nurses and a Director of Nursing (DON). Our DON was (V4) she called in one day in October, then was a no call no show and never returned to work. On 12/8/21 at 5:50 am, V15, CNA stated the following: Almost every time I work, I have to transfer residents with a (full mechanical lift) by myself. This has been going on for almost a year. I work by myself one or two nights every week, by myself. Sometimes the nurse can help but sometimes they are busy. I have to do it alone. (V3, RN, Acting Administrator), (V4, previous Director of Nursing) and (V7, Social Service Director/ Assistant Administrator) have all been told, we (unidentified nursing staff) don't feel safe working alone doing transfers and we can't give good care to all the residents in the facility short staffed. They have all told me they are trying to get more CNA's but I don't believe that. I am still working by myself for the full facility. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/8/21 at 4:00 am V14, Registered Nurse (RN) stated the following: What happen with (R4) was, I was watching call lights and getting medication pass set up outside B-Hall (Memory Care Unit), while (V9, previous Certified Nursing Assistant/ CNA) was doing rounds (room checks and care) on C-Hall and A-Hall. (R4) fell and we didn't know it. (R4) fell in his room and we had no idea how long he was on the floor. Neither (V9, CNA) or I (V14, RN) had been over there (B-Unit) in about an hour and a half. It takes about 45 minutes to do each A-Hall and C-Hall rounds. (V9, previous CAN) found (R4) on the floor of his room on B-Unit, after doing rounds outside the B-Unit. (R4) had a lot of blood coming from his head and blood on the floor. He was alert but has Dementia and could not say what happened. I applied pressure, got vital signs, did neuros (neurological) assessments, and sent him to the hospital. He got (treated) with at least five staples in his head and came back to the facility. V14, RN also stated the following: What happen with (R5), it was change of shift, days to evening. I was receiving report from days and passing meds (medication) outside the unit (B, locked memory care). There was no CNA on memory care after 6:30 pm end of shift until (V8, CNA) went over to B-unit and found (R5) on the floor. (V8, CNA) had been doing rounds on A-Unit and C-Unit. Around 7:45 pm Sunday (12/5/21), (V17, RN) said (V8, CNA) found (R5) on the floor. I went to B-Unit immediately. (R5) was on the floor and had a laceration to her head. I did vital signs, neuro (neurological assessment), applied pressure to the wound and sent her out (to the hospital). (R5) came back (from the emergency room) with one staple to her head. V14, RN also stated I have been complaining about staffing to (V4, previous Director of Nursing) and (V7, Social Service Director, Assistant Administrator) weekly for about three months. I complained to (V4, previous Director of Nursing and V7, SSD) that it is not safe for the residents and residents are not receiving the quality of care that they should. There are times between 6:00 pm and 8:00 pm I have no CNA (Certified Nursing Assistant) for the entire building. V14, RN also stated: When it is just me (V14, RN,) I cannot adequately provide care, answer call lights and do (administer) meds (medication). On 12/8/21 at 10:30 am V8, Certified Nursing Assistant (CNA) stated the following: I have had to work alone on evenings a couple of times (unidentified) for and hour or two until the nurse (unidentified) could get another staff member in here to work. I have had to do (full mechanical lift) transfers alone. The evening (12/5/21), (R5) fell . I did rounds on B-Unit (Memory Care locked unit) after I completed rounds on A and C units. I (V8, CNA) found (R5) in (R14's) room on the floor about 8:00 pm or 9:00 pm. (R14) was trying to get (R5) up (from the floor). I called for help and the nurse (V14, RN) came and assessed (R5) and sent her to the ER. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/7/21 at 4:05 pm V23, Memory Care Unit Coordinator stated All residents should be supervised but the memory care unit (B-Unit) residents more so because they can not remember to put on their call light for staff assistance. (R4) fell in the last month which resulted in a laceration to (R4's) head. He had to get numerous staples in the back of his head. No one knows what really happened because there were no staff working on B-Hall (Memory Care Unit) that night. The night shift is consistently short staffed. The night CNA's (Certified Nursing Assistance) working A and C halls, outside the B unit (locked memory care) are supposed to provide the care and check on the residents. I don't know if that is happening. Frequently the day shift CNA's complain that residents are not being changed (incontinence care). There are odors of urine when I come in each morning. I am not a Nurse or CNA so, I cannot provide personal care. (R5) had a fall a couple days ago which also resulted in staples to the back of her head. (R5) is not supposed to get up on her own. There was not a staff member over here (B-Unit) when (R5) fell . How long (R5) was on the floor is unknown. Staff do transfer residents by (full mechanical lift) with only one staff member because even on evenings there are not always two staff available. V23 also stated I am leaving (facility employment) in two days which is directly related to the facility not providing staff to care for the residents on B Unit. Management (unidentified) is totally aware and have done nothing to get more staff. On 12/8/21 at 4:20 pm V18, Physician / Medical Director stated I (V18) am not aware that one CNA was taking care of all residents on their own. This was never reported to me. For the quality of care required for these residents nursing staff should meet the minimum staffing requirements. I am not sure what that is for this facility. Staffing should be based on the level of care needed. Incontinence care should be provided or offered several times per shift. Several of the residents in this facility require a skilled level of care. There should always be enough staff working to maintain a safe environment. Falls do happen despite all we do to prevent them. It should never be because there was not enough staff to supervise these residents. The memory care unit would require constant staff supervision due to the residents on that unit's inability to recognize safety precautions. I am aware the (R4, R5, R9) have had falls in the facility. Each of those falls were reported and orders were given to send to the hospital for evaluation and treatment. Most recent, (R4 ad R5) both fell resulting in lacerations to the head which required ER evaluation and treatment. I did not realize there was no supervision on the unit at the time of these falls. Of course those injuries could have been prevented had the (R4 and R5) not fallen. On 12/14/21 at 11:00 am V7, Social Service Director/ Assistant Administrator stated staffing was really bad in November and there were several times that CNA's called off the week of Thanksgiving leaving one CNA to work the floor for all units. When I am informed I come in to help. I am not a CNA but I do answer call lights and assist the CNA's. There were times no one notified me. I couldn't help if I didn't know. V7 also stated The optimum staffing required in the facility with a census in the 50's is two nurses and three CNA's on days and evenings (shift) and nights (shift) should always have one nurse and two CNA's.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 31642 Based on interview and record review the facility failed to employee a full time Director of Nursing, November 4, 2021 - December 8, 2021. This failure has the potential to affect all 56 residents residing in the facility. Findings include: On 12/8/21 at 9:40 am V3, Registered Nurse\ Interim Administrator stated We are advertising on (Private company) website online and use agency for staffing. We are and doing interviews constantly trying to hire new CNA's, Nurses and a Director of Nursing (DON). Our DON was (V4) she called in one day in October, then was a no call no show and never returned to work. V4, Previous facility Director of Nursing Termination Notice dated Novemeber 4, 2021 documents V4 was hired 1/13/20 and facility corporation ceased V4's employment on Novemeber 4, 2021. The facility Nursing Midnight Census dated 12/6/21 documents 56 residents reside in the facility.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 31642 Based on observation, record review, and interview, the facility failed to post daily nurse staffing information. This failure affects all 56 residents residing in the facility. Findings include: On 12/7/21 at 11:50 am the facility's posting of daily nurse staffing was not posted in the facility. V5, Business Office Manager stated she knows there is supposed to be staff postings but does not do the schedule so, is not sure why the staffing is not posted. On 12/7/21 at 3:25 pm V7, Social Service Director / Acting Assistant Administrator stated It totally slipped my mind to post staffing. I am not gonna (going to) lie, I have not been posting it. The facility Nursing Midnight Census dated 12/6/21 documents 56 residents reside in the facility.