Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009765	A. BUILDING: ______ B. WING ______	C 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

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S 000	Initial Comments Complaint Investigation# 2168992/IL140944	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b)6 300.1210c) 300.1230f) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. Section 300.1230 Direct Care Staffing f) The number of staff who provide direct care who are needed at any time in the facility shall be based on the needs of the residents, and shall be determined by figuring the number of hours of direct care each resident needs per day. These Requirements were not met as evidenced by:	S9999	Attachment A Statement of Licensure Violations	

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

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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

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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 11/9/21 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 9/13/21 documents R4 is at high risk for falls = high risk if greater than 10 points. R4's scored is documented as 14 (high risk).

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)

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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 10/18/21 documents the following: R5 has a Brief Interview of Mental Status (BIMS) score of six out of 15,

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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 10/12/21 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)."

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.

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S9999	Continued From page 5 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	S9999		

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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."

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

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S9999	Continued From page 7 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	S9999		

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S9999	Continued From page 8 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." (B)	S9999		