

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  IL6009765	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/11/2022
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NAME OF PROVIDER OR SUPPLIER  WATSEKA REHAB & HLTH CARE CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 715 EAST RAYMOND ROAD WATSEKA, IL 60970
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S 000	Initial Comments  FRI of 8/21/2022\IL150888	S 000		
S9999	Final Observations  Statement of Licensure Violations  300.610a) 300.1210b) 300.1210d)6 300.3240g) 300.3210t)  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	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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NAME OF PROVIDER OR SUPPLIER  <b>WATSEKA REHAB &amp; HLTH CARE CTR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>715 EAST RAYMOND ROAD</b> <b>WATSEKA, IL 60970</b>
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S9999	<p>Continued From page 1</p> <p>resident to meet the total nursing and personal care needs of the resident.</p> <p>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:</p> <p>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.</p> <p><b>Section 300.3240 Abuse and Neglect</b></p> <p>g) A facility shall comply with all requirements for reporting abuse and neglect pursuant to the Abused and Neglected Long Term Care Facility Residents Reporting Act.</p> <p><b>Section 300.3210 General</b></p> <p>t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.</p> <p>These requirements were NOT MET as evidenced by:</p> <p>Based on record review and interview the facility failed to ensure one resident (R1) was not subjected to physical and sexual abuse by another resident (R2). These failures resulted in R1 experiencing bruising, pain and swelling to R1's right eye area and emotional distress as verbalized by (R1) stating (R1) felt ashamed after being sexually abused by R2. These failures</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>affected two residents (R1, R2) out of three residents reviewed for abuse in a sample list of ten residents.</p> <p>Findings include:</p> <p>R1's undated Face Sheet documents medical diagnoses of Chronic Obstructive Pulmonary Disorder (COPD), Major Depressive Disorder, Depression, Bipolar, Brain Tumor, Need for Personal Care and Fatigue.</p> <p>R1's Minimum Data Set (MDS) dated 7/5/22 documents a Brief Interview for Mental Status score of 6 out of 15 possible points indicating R1 is severely cognitively impaired. This same MDS documents R1 requires limited assistance of one person for bed mobility and extensive assistance of one person for transfers, dressing, toileting and personal hygiene.</p> <p>R1's Initial Incident Report to Illinois Department of Public Health dated 8/25/22 documents "Reported to (V1) Administrator that 62 year old female with Brief Interview for Mental Status (BIMS) score of 6 alleged to (R10) Hospice (Certified Nurses Aide) that an unidentified male at this time entered (R1's) room Sunday (8/21/22) evening and attempted to inappropriately touch (R1's) chest. (R1) then struck (R2's) hands away and reports that (R2) struck back at (R1). Investigation immediately investigated."</p> <p>R1's Final Incident Report to Illinois Department of Public Health dated 8/29/22 documents "The facility received an allegation of a physical altercation between (R1) and (R2). It was reported that (R2) entered (R1's) room at some point in the evening and began to inappropriately touch (R1) on chest area. (R2) was escorted out</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>of (R1's) room per staff on Tuesday (8/23/22) evening."</p> <p>R1's Assess, Intercommunicate, Manage (AIM for Wellness) report dated 8/25/22 documents "darkness under Right eye. Right eye slightly puffy."</p> <p>V16 Hospice Physician statement dated 8/25/22 documents "Spoke with (R1) in (R1's) room and (R1) was noted to have a bruised eye. When asked what occurred (R1) stated (R2) came into room on Sunday 8/21/22 at evening time and said, 'it's party time' and began trying to touch (R1's) breasts and buttock area and (R1) told (R2) firmly to stop. (R2) proceeded to try to touch (R1's) genital area but because (R1) was wearing an incontinence brief (R2) then stuck (R2's) hand under (R1's) pants and tried to reach down (R1's) incontinence brief but (R1) yelled 'Stop' and 'Help' and swatted (R2) away. (R1) stated (R2) then slapped (R1's) Left cheek and 'punched' Right eye. (R1) has had bruising and pain around Right eye. Head, Ears, Eyes, Nose, Throat (HEENT): Positive for Ecchymosis around Right eye with tenderness on palpation."</p> <p>R2's Minimum Data Set (MDS) dated 7/11/22 documents R2 as being severely cognitively impaired with diagnoses including Anxiety, Parkinson's Disease, Tremors, Barrett's Esophagus without Dysplasia, Intellectual Disability, Open Angle Glaucoma, Psychosis with Behaviors and Depression. This same MDS documents R2 requires limited assistance with bed mobility and transfers.</p> <p>R2's Physician Order Sheet (POS) dated August 1-31, 2022 documents a physician order for "Weight bearing as tolerated. Up as tolerated."</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>On 9/4/22 at 10:30 AM R1 stated "(R2) walked into my room Sunday night (8/21/22). (R2) walked over to me and shook (R2's) hips and said 'it's party time'. (R2) grabbed my boobs and crotch. I started to bat (R2's) hands away with my hands and that is when (R2) slapped me. (R2) used his open hand to slap the Left side of my face by my Left eye. (R2) kept putting (R2's) hands down the front of my incontinence brief. I yelled 'stop' and 'help' over and over. I swatted (R2's) hand away again and (R2) used (R2's) closed fist to punch me in the Right eye. The Left eye hurt but it didn't bruise. (R2) blackened my Right eye. It hurt awful. I felt so ashamed but (R2) didn't know what (R2) was doing. (R2) is not right in the head. I reported this to (V12) Certified Nurse Aide (CNA) the next day (8/22/22). I also told (V8) Social Worker from Hospice a few days later. I do not want anything to happen to (R2). (R2) is out of (R2's) mind. I feel sorry for (R2). Apparently (R2) thought I was (R2's) girlfriend. I don't want (R2) to get in trouble or go to jail. I just don't want (R2) in my room again. (R2) came to my room the next day. (R2) stood inside the doorway and apologized and then left with staff. I have not seen (R2) since then."</p> <p>On 9/4/22 at 1:45 PM V12 Certified Nurse Aide (CNA)/CNA educator stated V12 walked into R1's room on 8/22/22 to check on R1 and noticed R1 had a bruise around R1's Right eye. V12 stated "I asked (R1) how (R1) got that black eye and (R1) told me (R2) hit (R1) in the eye. I told (V6) Registered Nurse (RN) about (R1's) black eye and allegations. Later that same day (V13) Unit Aide arrived and V13 reported to me that (R1) had told (V13) that (R2) hit (R1) in the eye after touching (R1) breasts and trying to put (R2's)</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>hands down (R1) incontinence brief."</p> <p>On 9/4/22 at 3:30 PM V14 Social Service Director stated V14 was made aware of the incident with R1 and R2 on Thursday 8/25/22. V14 stated "to be honest I did not make any notes or talk to either R1 or R2 about this incident. I told (V1) that I would catch up on Tuesday (9/5/22). I wasn't even aware that there was any kind of abuse. I was just told 8/25/22 that (R1) was upset and something happened. I did not know what. I did not update the behavior tracking sheets for (R2)."</p> <p>On 9/4/22 at 4:15 PM V1 Administrator stated "I was notified on 8/25/22 that there was an allegation of abuse between (R1) and (R2). I immediately came into facility and started the investigation. (R2) was moved to another room on another hall. One to one supervision was initiated. We (facility) notified Hospice and they came into assess and talk with (R1). The investigation started 8/25/22. No one told me about this incident prior to 8/25/22."</p> <p>On 9/5/22 at 9:15 AM V15 Unit Aide stated V15 was working on 8/22/22 when R1 called V15 into R1's room. V15 stated "after I was in (R1's) room, (R1) asked me 'how bad is (R1's) eye?' (R1's) Right eye was red underneath, so I asked (R1) what happened. (R1) told me that (R2) hit (R1) and (R2) put (R2's) hands down (R1's) pants Sunday (8/21/22) night."</p> <p>On 9/5/22 at 9:45 AM V6 Registered Nurse (RN) stated "(V12) Certified Nurse Aide (CNA) reported to me on 8/22/22 that (R1's) eye was bruised. I assessed both of (R1's) eyes. (R1's) Right eye was red a little bit all the way around on top of lid and on bottom lid. I asked (R1) if (R1) eye hurt</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>and (R1) told me no. I didn't ask (R1) what happened to it. Why would I ask that? I did not report (R1)'s Right eye redness to (V1) Abuse Coordinator."</p> <p>On 9/5/22 at 10:00 AM V8 Hospice Social Worker stated V8 was notified by the Hospice supervisor on 8/25/22 to come to facility and talk with R1. V8 stated V8 was notified on 8/25/22 that there was an allegation of abuse and that V8 should speak with R1 that day. V8 stated V8 came to the facility on 8/25/22, which was not a regularly scheduled visit with R1. V8 stated "I have gotten to know (R1) quite well through our conversations." V8 stated R1 is able to verbalize needs and reports to staff of any abuse would be accurate. V8 stated "(R1) just gets confused on the dates, not what happens." V8 stated R1 told V8 that R2 had touched R1's breasts and tried to put R2's hands down R1's incontinence brief. V8 stated R1 told V8 that R1 did not want anything to happen to R2 because R2 did not know what R2 was doing. V8 stated "I tried to pin (R1) down on what date this incident occurred because (R1) can sometimes get dates mixed up. (R1) told me what programs (R1) was watching on television and those programs are (R1's) favorite shows that are only on Sunday evenings. So I know (R1) was right about the date the incident occurred. (R1) knows the television shows inside and out. (R1) has favorites shows (R1) watches and knows what days they air."</p> <p>On 9/5/22 at 11:00 am V2 Director of Nurses stated V2 could not provide documentation that the facility immediately implemented interventions to protect R1 from R2 after R1 reported to staff on 8/22/22 that R2 sexually and physically abused R1 on 8/21/22. V2 further stated V2 could not provide documentation that R2 was</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>consistently monitored on a one to one basis after R2 was placed on one to one monitoring on 8/25/22.</p> <p>On 9/6/22 at 1:30 PM V1 Administrator stated "We (facility) now see that (R2) did actually abuse (R1) on 8/21/22."</p> <p>On 9/6/22 at 1:00 PM V17 Medical Director stated R2 has had a history of aggressive and agitated behaviors. V17 stated R2 has been sent to the emergency department for mental health evaluation every time R2 has had extreme behaviors. V17 stated (V3) Registered Nurse (RN) texted me on Sunday 9/4/22 that a Public Health Surveyor was in the facility to investigate this abuse between residents. That was the first time I had been made aware of any type of incident. If the facility would have notified me of this allegation of physical and sexual abuses, I would have definitely given the order to send (R2) to the emergency room. (R2) is not appropriate for this facility. I do not believe (R2) is a danger to any other females that reside in the facility but (R2) could definitely be a danger to (R1) again." V17 stated "the facility should have immediately placed an intervention for (R2) that would work. The continual monitoring obviously did not work since (R2) entered (R1)'s room again two days later."</p> <p>On 9/6/22 at 1:30 PM V1 Administrator stated "We now see that (R2) did actually abuse (R1) on 8/21/22. Since (R2) was not on continuous monitoring or have any type of interventions in place at that time, (R2) was able to enter (R1)'s room again on 8/23/22. I originally thought that (R2) had assaulted (R1) on 8/23/22 when (V9) CNA redirected (R2) out of (R1)'s room but that must have been when (R2) came back to (R1) to apologize. (R2) should have not been allowed to</p>	S9999		
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S9999	<p>Continued From page 8</p> <p>be in (R1's) room with (R1) after assaulting (R1)."</p> <p>On 9/6/22 at 3:20 PM V9 Certified Nurse Aide (CNA) stated V9 was working the evening of 8/23/22. V9 CNA stated "Tuesday (8/23/22) evening I was walking by (R1's) room and (R1) asked me to come in. (R1) was not yelling and did not seem upset. I saw (R2) standing just inside (R1's) doorway. I escorted (R2) out of (R1's) room without any difficulty." V9 stated "We (staff) have to watch (R2). We (staff) are always finding (R2) in other resident rooms."</p> <p>The facility Abuse Prevention Program Policy revised 11/28/2016 documents the following "The facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation. The facility is committed to protecting residents from abuse including but not limited to facility staff, other residents, consultants, volunteers, staff from other agencies providing services to the individual family members or legal guardians, friends, or any other individuals. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, mental anguish or pain. 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.</p> <p>Resident Protection Investigation Paths: Possible Sexual Abuse: Definition: Sexual Abuse is non-consensual sexual contact of any type with a resident. If the allegation is physical contact that did not involve penetration, proceed directly with investigation procedures in Step 5 and interview of witnesses in Step 6. Physical abuse includes hitting, slapping, pinching, kicking and controlling behavior through corporal punishment."</p>	S9999		

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