Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
AND PERIOD CONCESSION		DETTI TOTTION HOMBEN.	A. BUILDING:		COMP	reien		
IL6009765		B. WING		10/13/2023				
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
WATCEK	WATSEKA REHAB & HLTH CARE CTR 715 EAST RAYMOND ROAD							
TIAI SEN	A RENAD & REID CA	WATSEKA	L, IL 60970					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTM (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE			
S 000	Initial Comments		S 000					
	Annual Licensure C	ertification Survey						
S9 <b>99</b> 9	Final Observations		S9999					
	Statement of Licensure Violations							
	300.610a)							
	300.1210b)							
	300.1210d)1 300.3240a)							
	Section 300.610 Re	esident Care Policies						
	procedures governifacility. The written be formulated by a Committee consisting administrator, the amedical advisory confined and other policies shall complicates the facility and shall by this committee, cand dated minutes of the written policies.	dvisory physician or the immittee, and representatives in services in the facility. The y with the Act and this Part. shall be followed in operating be reviewed at least annually locumented by written, signed of the meeting.						
ilinois Depar	b) The facility shall pand services to atta practicable physical well-being of the reseach resident's complan. Adequate and care and personal of	provide the necessary care in or maintain the highest , mental, and psychological sident, in accordance with prehensive resident care properly supervised nursing are shall be provided to each total nursing and personal		Attachment A Statement of Licensure Violation	В			

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

TITLE

(X6) DATE

PRINTED: 12/18/2023 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ B. WING 1L6009765 10/13/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 715 EAST RAYMOND ROAD WATSEKA REHAB & HLTH CARE CTR WATSEKA, IL 60970 PROVIDER'S PLAN OF CORRECTION **SUMMARY STATEMENT OF DEFICIENCIES** (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) S9999 S9999 Continued From page 1 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Requirements were not met as evidenced by: Based on interview and record review the facility failed to effectively manage and treat ongoing pain for two of three residents (R11, R35) reviewed for pain on the sample list of 25. These failures resulted in R11, on hospice, screaming out in severe pain throughout the night. Findings include: The Pain Prevention and Treatment policy dated 12/7/14 documents it is the facility's policy to assess for and reduce the incidence and severity of pain in order to enhance resident's quality of

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life. Pain is subjective and should be documented

R11's Medical Diagnoses list dated 10/12/23 documents Dementia with Agitation, Bipolar Disorder, Schizoaffective Disorder, Osteoarthritis, and Osteoporosis. R11's Physician Order Sheet

as perceived by the resident.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND PLAN OF CORRECTION		DECT OF TOTAL	A. BUILDING:		COMP	LEIED
IL6009765		B. WING		10/13/2023		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
WATSEKA REHAB & HLTH CARE CTR 715 EAST RAY WATSEKA, IL				ROAD		1
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
S9999	PROVIDER OR SUPPLIER  AR REHAB & HLTH CARE CTR  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 2  dated October 2023 documents R11 is on Hospice and is prescribed Morphine Sulfate (narcotic analgesic) scheduled and as needed for discomfort.  R11's Minimum Data Set dated 8/11/23 documents R11 is severely cognitively impaired. R11's Care Plan dated 7/26/23 documents R11 suffers from chronic pain. Staff are to anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Staff are to notify the physician if interventions are unsuccessful. R11's Care Plan also documents R11 is receiving Hospice Services and the goal is to remain as comfortable as possible.  R11's Medication Administration Record dated October 2023 documents on the night of 10/7/23 through the morning of 10/8/23, R11 did not receive any of the 'as needed' doses of Morphine Sulfate. R11 received her last scheduled dose of Morphine Sulfate around 8:00 PM on 10/7/23.  R35's Medical Diagnoses list dated 10/12/23 documents difficulty Walking, Muscle Weakness, and Bipolar Disorder. R35's Physician Order Sheet dated October 2023 documents R35 is prescribed Acetaminophen every eight hours as needed or Percocet (opioid analgesic) every four hours as needed for pain.  R35's Care Plan dated 6/8/23 documents R35 suffers from chronic pain. Staff are to anticipate the resident's need for pain relief and respond immediately to any complaint of pain.  R35's Medication Administration Record dated October 2023 documents on the night of 10/7/23 through the morning of 10/8/23 R35 was given		S9999			
	two doses of Perco	cet pain medication.		46		

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PRINTED: 12/18/2023 **FORM APPROVED** Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING IL6009765 10/13/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 715 EAST RAYMOND ROAD WATSEKA REHAB & HLTH CARE CTR WATSEKA, IL 60970 **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) S9999 S9999 Continued From page 3 On 10/11/23 at 2:00 PM R35 stated she had issues with the V10 LPN on the night of 10/7/23. R35 stated she is in almost constant pain and V10 was refusing to give her pain medication timely. R35 stated V10 was rude and told her she was not giving her pain medication and slammed the door when she left the room. R35 rated her pain as a 10/10 and stated the staff do not do enough to help her relieve her pain. R35 stated V10 LPN also just let R11 who was R35's roommate scream and yell in pain all night long. R35 stated R11 sounded so uncomfortable and was crying and it was horrible to listen to. On 10/12/23 at 1:00 PM V12 Certified Nurses Assistant (CNA) stated on the night shift of 10/7/23 both R11 and R35's pain was ignored by their assigned nurse V10 Licensed Practical Nurse (LPN), V12 stated R11 is on hospice, has impaired cognition, and will yell out when she is agitated or in pain. V12 stated on the night of 10/7/23, R11 was yelling out and when asked what was wrong, R11 stated she hurt and kept repeating that over and over. V12 stated R11 was crying and appeared to be in pain. V12 stated she reported this to V10 LPN and V10 snapped at V12 and said she was not going to give R11 anything for pain. V12 stated more than one staff member reported R11 being in pain to V10 but V10 would not administer R11's pain medication. V12 stated R11 was crying and yelling out in pain all throughout the night shift. V12 also stated R35 began to complain about severe pain in the early morning hours of 10/8/23. V12 stated she

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reported this to V10 LPN and V10 told her to mind her own business. V12 stated R35 repeatedly had on her call light complaining of pain. V12 stated R35 told her V10 LPN had entered her room to answer the call light and told

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**FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ B. WING IL6009765 10/13/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 715 EAST RAYMOND ROAD WATSEKA REHAB & HLTH CARE CTR WATSEKA, IL 60970 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) S9999 Continued From page 4 59999 her she was not getting anything for pain, shut off the light, and slammed the door. V12 stated R35 was visibly upset and in pain. On 10/12/23 at 1:46 PM V20 Certified Nurses Assistant (CNA) stated on the night shift of 10/7/23 V10 Licensed Practical Nurse (LPN) ignored R11 and R35's pain. V20 stated R11 was screaming in pain all throughout the night shift from about 9:00 PM through the end of the shift. V20 stated she told V10 LPN and other staff told her as well about R11's pain and R35's pain, V10 LPN did not address R11's pain and did not give her any pain medication. R11 cried and velled out "it hurts" all throughout the night shift on 10/7/23. V20 stated R11 normally does not yell out and cry all night long and normally sleeps through the night. V20 stated R35 complained of pain in the early hours of 10/8/23 and V10 ignored her requests for something for pain. On 10/12/23 at 2:30 PM V13 Certified Nurses Assistant (CNA) stated on the night shift of 10/7/23, R11 cried in pain and yelled out for hours and V10 Licensed Practical Nurse did nothing for her (R11). V13 CNA stated R11 was yelling out and saying she hurt. V10 LPN was told by multiple staff and did nothing to help R11, V13 CNA stated R35 also stated she needed something for pain multiple times and V10 LPN was told and did nothing. V13 stated R35 told her V10 LPN had entered her room to answer the call light, R35 told her she needed pain medication, and V10 told her she was not getting anything for pain, shut off the light, and slammed the door. On 10/12/23 at 5:08 PM V11 Licensed Practical

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Nurse (LPN) stated she worked the night shift on 10/7/23. V11 stated R11 was in a lot of pain that night and was screaming out and crying and

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	CURRECTION I	IDENTIFICATION NUMBER:	10 100 00 00	E CONSTRUCTION	COMPLE	URVEY
AND PLAN OF CORRECTION			A BUILDING		COMM CL	-120
IL6009765		B. WING	B. WING		10/13/2023	
NAME OF PROV	VIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE		
WATSEKA REHAB & HLTH CARE CTR 715 EAST RAYMOND ROAD						
***************************************		WATSE	KA, IL 60970			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTS (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	ON SHOULD BE COMPLETE DATE	
S9999 Co	ontinued From pa	ge 5	59999			
sta sta sta sta sta wa co ref LF ne ho a ' Wa R3 Or Nu 10 an sc an wa V1 V1 sh sh sh o wa me the in o o o o o o o o o o o o o o o o o o	ated she told V10 ated V10 refused edication. V11 sta ant to care for her buld leave the facil fused to give R11 PN stated R35 was eds her prescribe ours. R35 was con 10/10. V11 stated as refusing to bring 35 was visibly ups on 10/13/23 at 9:44 ourse confirmed wo 0/7/23 and was the old R35. V10 confirmed wo 10/13/23 at 9:44 ourse confirmed wo 10/13/23	hroughout the night. V11 LPI LPN about R11's pain. V11 to give R11 any pain ted she told V10 if she didn't residents properly then she lity. V10 refused to leave and any pain medication. V11 is also complaining of pain and pain medication every four inplaining of pain and rating it R35 told her that V10 LPN ing her pain medication and et and in pain.  AM V10 Licensed Practical orked the night shift on eassigned nurse for both R1 med she administered R11's it sulfate but did not give her ites. V10 LPN confirmed staff iter concerning R11's pain but R11 was in that much pain. Is she did spend most of the a unit where the doors were at R11 yelling out or crying in med R11 and R35's room is unit. V10 LPN confirmed stagiving R35 her pain eshe passed medications to est. V10 LPN confirmed if a ain, request pain medication dication available to be giver should be administered.	nd f			
ale ex	ert to person, she' press pain but ca	s very confused and can n't say the location of her pa R11 does have scheduled		€		
Mo Mo	orphine Sulfate for	r pain and 'as needed' needed for further discomfor	t			

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A BUILDING: \_ **B. WING IL6009765** 10/13/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 715 EAST RAYMOND ROAD **WATSEKA REHAB & HLTH CARE CTR** WATSEKA, IL 60970 **SUMMARY STATEMENT OF DEFICIENCIES** (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**) S9999 Continued From page 6 59999 V30 stated if R11 or any patient for that matter is in pain and crying out, seems agitated, is crying or stating they are hurting, the nurse should give the prescribed pain medication that is available. V30 confirmed if R11 was exhibiting pain by yelling, crying, and stating she was hurting. V10 LPN should have administered the 'as needed' Morphine Sulfate. On 10/13/23 at 1:00 PM V2 Director of Nurses and V3 Director of Clinical Operations confirmed nurses should always address a resident's pain and discomfort by either giving pain medications or trying an alternative method of pain control. Both V2 and V3 both confirmed if those things are tried and the resident's pain is still not relieved. nursing staff should address uncontrolled pain with the resident's physician, Both V2 and V3 confirmed V10 LPN should have administered R11's 'as needed' pain medication when she was crying out in pain. Both V2 and V3 confirmed R35 is always complaining of pain and asks for her 'as needed' Percocet frequently. "B"