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 05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATSEKA REHAB & HLTH CARE CTR	715 EAST RAYMOND ROAD WATSEKA, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation: 2364035/IL159866	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)3) 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 resident to meet the total nursing and personal	S9999	Attachment A Statement of Licensure Violations	

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 05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATSEKA REHAB & HLTH CARE CTR	715 EAST RAYMOND ROAD WATSEKA, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 1 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. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These Requirements were not met as evidenced by: Based on interview and record review the facility failed to promptly notify the physician of an acute change in condition, document changes in condition, and monitor/assess for changes in condition for two (R1, R7) of three residents reviewed for hospitalization in the sample list of 12. This failure resulted in R1's multiple hospital readmissions for fluid volume overload, pleural effusions, pulmonary edema, acute hypoxic respiratory failure and congestive heart failure. The facility also failed to monitor anticoagulant use for one (R7) of three residents reviewed for hospitalizations in the sample list of 12. Findings include: 1.) R1's Diagnoses List dated 5/24/23 documents R1 has type II Diabetes Mellitus with Chronic	S9999		

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 05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATSEKA REHAB & HLTH CARE CTR	715 EAST RAYMOND ROAD WATSEKA, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 2 Kidney Disease. R1's Physician Order dated 3/22/23 documents R1 receives hemodialysis at a dialysis center three times weekly on Mondays, Wednesdays, and Fridays. R1's Brief Interview for Mental Status score dated 5/5/23 documents R1 is cognitively intact. R1's Care Plan dated 11/14/22 documents R1 has End Stage Renal Disease, is noncompliant with diet, and includes an intervention to weigh monthly and report weight changes to the physician and dietitian. This care plan documents R1 receives dialysis three times weekly and includes interventions to monitor for changes in condition including fluid status, cognition and activities of daily living needs, and report these changes to the dialysis center. This care plan documents R1 uses oxygen as needed for shortness of breath and includes interventions to monitor R1's oxygen saturation every shift and as needed, and notify the physician of concerns. R1's Nursing Note dated 4/16/2023 at 6:51 PM documents R1 refused all medications, had not ate all day, and stated R1 did not feel well. There is no documentation that V16 (R1's Physician) was notified. There are no documented monitoring/assessments of R1 between 4/16/23 and 4/17/23. There is no documentation that R1 was transferred to the hospital on 4/17/23 or the reason for the hospital transfer. R1's Emergency Room Assessment dated 4/17/23 at 10:31 AM documents R1 complained of nausea, vomiting, shortness of breath for the past two days, and R1 has no cardiac history. R1's last dialysis was on 4/14/23, with dialysis scheduled for 4/17/23. This assessment documents R1 had similar symptoms and hospitalization with dialysis about a month ago.	S9999		

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 05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATSEKA REHAB & HLTH CARE CTR	715 EAST RAYMOND ROAD WATSEKA, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3	S9999		

R1's lungs were diminished with wet crackles, oxygen saturation was 50% (normal is 95% or higher), blood pressure was 188/118, and pulse was 92. R1 weighed 165 pounds (lbs). R1's chest x-ray dated 4/17/23 documents R1 had changes that were suspicious for congestive heart failure with developing pulmonary edema and pleural effusions (fluid in the lungs). R1's Emergency Room Note dated 4/17/23 documents R1 was given intravenous Lasix (diuretic), placed on high flow oxygen, then placed on Bilevel positive airway pressure (BIPAP), and transferred to a higher level hospital. R1's Hospital Progress Note dated 4/21/23 documents R1 was transferred from an outside hospital for acute hypoxic respiratory failure, and nephrology was consulted for dialysis for fluid volume overload and hyperkalemia. R1's weight on 4/21/23 was 145 lbs and 6.4 ounces.

There are no routine monitoring of R1's weights, blood pressure, and oxygen saturation in R1's medical record. R1's weight on 2/1/23 was 167 lbs, on 4/19/23 and 4/23/23 R1 weighed 159 lbs. There are no other documented weights in April and May 2023 or documented assessments/monitoring of R1 after 4/22/23 until 4/30/23.

R1's Nursing Notes document the following: On 4/30/2023 at 6:03 PM oxygen was administered at 2 liters per minute due to R1's complaints of shortness of breath and coughing up phlegm. On 4/30/2023 at 6:37 PM R1 was R1's usual self earlier in the day, and now complained of shortness of breath. R1's blood pressure was 180/76, respirations were 26, and oxygen saturation was 94%. R1 had a cough with a clear amount of phlegm and a nebulizer treatment was administered. On 4/30/2023 at 7:41 PM R1 was

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 05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATSEKA REHAB & HLTH CARE CTR	715 EAST RAYMOND ROAD WATSEKA, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4 sitting on the side of the bed and complained of feeling "much worse". R1's blood pressure was 180/104, pulse was 98, Oxygen saturation was 94%. The physician was notified and R1 was transferred to the local hospital. R1's Hospital Discharge Summary dated 5/1/23 at 11:41 AM documents the following: R1 admitted to the hospital on 4/30/23 for complaints of shortness of breath. R1 reported having hemodialysis the day prior with 3.5 liters of fluid removed, and later that day R1 had sudden onset of shortness of breath and productive cough. R1's dialysis is scheduled three times weekly on Mondays, Wednesdays, and Fridays (indicating R1's last dialysis day was on 4/28/23.) R1's oxygen saturation was 65% on room air and R1 was placed on BIPAP. R1's chest x-ray showed volume overload with mild to moderate pleural effusions, pulmonary infiltrates, pulmonary edema, and congestive heart failure with mild cardiomegaly. R1 readmitted to the facility on 5/5/23 and there are no documented assessments/monitoring, or changes in condition between 5/5/23 and 5/15/23. R1's Nursing Note dated 5/15/23 at 3:17 PM documents R1's family member called and inquired how R1's condition was earlier in the day and if R1 went to dialysis. This family member reported that R1 had not felt good during the night. The nurse informed R1's family that R1's vital signs were obtained (these vital signs are not recorded in R1's medical record) and R1 was transferred to dialysis. R1 was transferred from dialysis to the local hospital and intensive care unit with diagnoses of hyperkalemia, shortness of breath, dialysis, and pulmonary edema. There are no documented assessments or monitoring of R1 after R1 returned to the facility on 5/19/23.	S9999		

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 05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATSEKA REHAB & HLTH CARE CTR	715 EAST RAYMOND ROAD WATSEKA, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 5 On 5/23/23 at 8:41 AM R1 stated R1 went from dialysis to the hospital on 5/15/23 for shortness of breath, nausea, coughing, dizziness and sweating. R1 stated the facility had sent R1 to dialysis with R1's symptoms to see if dialysis would improve R1's symptoms, but the dialysis center told R1 there was nothing they could do for R1 and sent R1 to the hospital. R1 stated R1 was in a wheelchair and was on oxygen when R1 was transferred to dialysis, and R1's symptoms began on the night before around 6:00 PM. R1 kept waking up during the night and reporting R1's symptoms to the nurses, and R1 was not sure if the nurses reported R1's symptoms to V16 Physician. R1 stated R1 was hospitalized for pneumonia. R1 stated R1's symptoms are always the same and usually begin about 1-2 days prior to R1 being transferred to the hospital. R12 (R1's room mate) stated about 3-4 weeks ago R12 had to contact emergency services to request R1 be transported to the emergency room. R1 stated R1 had kept asking the nurses to send R1 to the hospital, and they refused saying R1 only needed dialysis. On 5/24/23 at 8:24 AM R1 stated R1 went to the local hospital in April and had to be transported to a higher level hospital for treatment. R1's symptoms had started the night before, and R1 had requested to go to the emergency room. R1 stated V2 Director of Nursing told R1 that R1 needed dialysis and did not contact 911 as R1 had requested. On 5/24/23 at 8:14 AM V31 Dialysis Nurse stated on 5/15/23 R1 arrived at dialysis in a wheelchair and on oxygen, normally R1 is ambulatory and does not use oxygen. R1 complained of being short of breath, sweating, and abdominal pain that had started the night before and the facility nurses had not addressed R1's symptoms. V31	S9999		

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 05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATSEKA REHAB & HLTH CARE CTR	715 EAST RAYMOND ROAD WATSEKA, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 6	S9999		

stated R1's health changes quickly and has a history of respiratory illness. V31 stated R1 was immediately transferred to the local hospital and admitted to the intensive care unit. V31 stated V31 spoke to V25 Licensed Practical Nurse on 5/15/23 who told V31 that R1 "did not look good" that morning. V31 stated R1 also reported that a few weeks prior R1 was experiencing similar symptoms and requested to go to the hospital, but R1 had to call 911 because the nurses would not.

On 5/24/23 at 8:29 AM V33 Certified Nursing Assistant stated there was a day that R1 went to dialysis in a wheelchair and on oxygen, and R1 did not return to the facility that day. V33 stated normally R1 is able to walk and take care of R1's self, and only uses oxygen as needed typically at night.

On 5/24/23 at 11:07 AM V2 Director of Nursing stated residents on dialysis should be weighed weekly and recorded in the electronic medical record. Vital signs, swelling in extremities, puffiness of the face, and assessing lung sounds are all part of monitoring/assessing for fluid overload. V2 stated we chart by exception and only when there are changes noted in the resident. V2 stated V2 would expect an assessment to be done and documented when a resident complains of not feeling well, and the physician should be notified. V2 stated vital signs are not always getting done. V2 stated R1 went in a wheelchair to dialysis on the morning of 5/15/23, and normally R1 is ambulatory and only uses oxygen after dialysis treatments when needed. V2 stated R1 does not always feel well on dialysis mornings. On an unidentified date V2 told R1 it was a scheduled dialysis day when R1 requested to go to the hospital for vomiting. V2

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 05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATSEKA REHAB & HLTH CARE CTR	715 EAST RAYMOND ROAD WATSEKA, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 7 stated V2 had to assist with another resident, and R1 called 911. On 5/24/23 at 2:57 PM V16 Physician stated R1 is noncompliant with R1's orders and medications which contributes to R1's fluid volume overload, and R1 receives dialysis three times weekly. V16 stated the facility should be monitoring R1's weights at least weekly, and blood pressure daily. V16 expects the nurses to complete an assessment including vital signs and oxygen saturation when R1 has a change in condition including of shortness of breath, dizziness, or nausea/vomiting. V16 stated R1 can have a rapid increase in blood pressure, and the nurses should notify V16 of their assessment and R1's change in condition/symptoms. V16 stated V16 is unable to manage R1's fluid volume overload in the facility, and R1 requires hospitalization and additional dialysis to treat R1's fluid volume overload. V16 stated if the facility is not monitoring R1 for signs/symptoms of fluid volume overload, then R1 could "go downhill fast" or possibly die. V16 stated V16 should have been notified of R1's change in condition and symptoms and R1 should have been sent to the emergency room on 5/14/23. R1 should not have been sent to dialysis in that condition. 2.) R7's Diagnoses List dated 5/24/23 documents R7 has End Stage Renal Disease, Kidney Failure, Atherosclerotic Heart Disease, Heart Failure, Type 2 Diabetes Mellitus, and history of myocardial infarction. R7's Care Plan revised 2/1/23 documents R7 receives dialysis three times weekly on Tuesdays, Thursdays, and Saturdays and includes interventions to monitor for changes and response to treatment, notify the dialysis center of	S9999		

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 05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATSEKA REHAB & HLTH CARE CTR	715 EAST RAYMOND ROAD WATSEKA, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 8 changes in condition including fluid status, cognition, and activities of daily living needs. There are no routine assessments or monitoring of R7 and R7's vitals signs and weight documented in R7's medical record. R7's Nursing Notes document the following: On 5/14/2023 at 1:37 AM R7 had 3+ pitting edema to bilateral lower extremities, complaint of numbness/tingling to bilateral upper/lower extremities, blood pressure was 137/100, pulse was 104, oxygen saturation was 93%, respirations were 18, and blood glucose results were high. The physician was notified and R7 was transferred to the hospital. On 5/17/2023 at 4:06 PM R7 readmitted to the facility and reported that R7 had dialysis with 3 liters of fluid removed. There are no documented assessments after 5/17/23. On 5/22/23 at 1:13 PM R7 refused all morning medications and insulin. R7 complained of vomiting and diarrhea and requested to go to the emergency room. R7's face was puffy and abdomen was distended. R7 was transferred to the hospital by ambulance. There are no documented assessments/monitoring of R7 on 5/21/23 and prior to 5/22/23 at 1:13 PM or that R7's physician was notified of any change in condition prior to 5/22/23. R7's Hospital Note dated 5/14/23 at 8:33 AM documents R7 presented with weakness and abdominal pain that began over the last week with some nausea/vomiting, decreased urine output, fluid retention, weight gain, and abdominal distention. R7's pelvis computed Tomography showed anasarca (accumulation of fluid/swelling of the whole body), pleural effusion, abdominal ascites (fluid).	S9999		

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 05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATSEKA REHAB & HLTH CARE CTR	715 EAST RAYMOND ROAD WATSEKA, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 9 On 5/23/23 at 1:11 PM V27 Certified Nursing Assistant stated on 5/21/23 R7 was overly tired and not out and about per R7's usual. V27 stated V27 served R7's supper tray then later that evening R7 went outside to smoke and V27 noticed R7's eyelids were swollen/puffy. V27 stated R7's ankles are always swollen, but R7 had no facial swelling prior. V27 stated V27 reported R7 feeling tired and R7's eyelid swelling to V30 Licensed Practical Nurse who said that V30 would assess R7. On 5/24/23 at 9:20 AM V26 Licensed Practical Nurse stated V26 reported to work on 5/22/23 at 10:00 AM and R7's face was puffy and abdomen was distended. V26 stated V26 last cared for R7 on 5/19/23 and R7 did not have facial swelling at that time. R7 complained of vomiting and diarrhea and was requesting to go to the hospital. It was passed on in report that R7 refused R7's morning medications. V26 stated R7 was transferred to the hospital around 11:00 AM. On 5/24/23 at 11:07 AM V2 Director of Nursing stated residents on dialysis are to be weighed weekly and recorded in the electronic medical record. Vital signs, swelling in extremities, puffiness of the face, and assessing lung sounds are all part of monitoring/assessing for fluid overload. V2 stated we chart by exception and only when there are changes noted in the resident. V2 stated V2 would expect an assessment to be done and documented when a resident complains of not feeling well, and the physician should be notified. V2 stated vital signs are not always getting done. V2 stated R7 was admitted to the hospital with fluid volume overload on 5/22/23. 3.) R7's Diagnoses List dated 5/24/23 documents	S9999		

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 05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATSEKA REHAB & HLTH CARE CTR	715 EAST RAYMOND ROAD WATSEKA, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 10 R7 has a history of Transient Ischemic Attacks and Cerebrovascular Infarction. R7's April and May 2023 Medication Administration Records documents R7's Coumadin (anticoagulant) was increased from 5 milligrams (mg) daily to 7.5 mg daily on 4/6/23 and then decreased to 3.5 mg daily on 5/1/23. The order dated 5/1/23 indicates to monitor R7's Protime (PT)/International normalized ratio (INR) daily with a therapeutic goal of 2.5-3 and to adjust the dose accordingly as recommended by the physician. There is no documentation that R7's PT/INR was monitored routinely after 3/29/23, and there are no orders for routine PT/INR. There is no documentation in R7's medical record that attempts were made to obtain R7's PT/INR, that R7 refused laboratory draws, or that R7's physician was notified of refusals. R7's PT/INR on 3/29/23 was 25.6 and 2.42. R7's Laboratory Requisitions dated 4/5/23 and 4/12/23 documents R7 refused blood draw for PT/INR. R7's Laboratory Requisitions 4/19/23 and 5/10/23 documents R7 refused laboratory draw, but does not document what laboratory test was ordered. R7's Nursing Notes R7 went on a leave of absence from the facility on 4/23/23. R7's Physician Progress Note dated 5/10/2023 at 1:54 PM documents R7 readmitted to the facility and had been hospitalized for an elevated INR and R7's brain computed Tomography indicated an increase in R7's brain bleed. On 5/24/23 at 11:07 AM V2 Director of Nursing stated PT/INR should be done at least monthly or per physician's orders after an increase in dosage of Coumadin. At 3:33 PM V2 stated stated there	S9999		

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 05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATSEKA REHAB & HLTH CARE CTR	715 EAST RAYMOND ROAD WATSEKA, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 11 were no orders to monitor PT/INR routinely and confirmed there were no PT/INR results after 3/29/23. V2 stated no one followed up on monitoring PT/INR after R7 readmitted to the facility. V2 stated R7 refused to have PT/INR drawn and the nurses should have notified the physician and documented in R7's medical record. V2 stated the facility does not have a policy on anticoagulant use/monitoring. The facility's Notification for Change in Resident Condition or Status revised 12/7/17 documents the physician will be notified of changes in resident's physical/emotional/mental conditions, refusal of treatment/medications, and transfer to hospital. Information related to the change in condition will be documented in the resident's medical record. (A)	S9999		