| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 145389 | A. Building<br>B. Wing | 08/28/2024 |

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| Watseka Rehab & Hlth Care Ctr | 715 East Raymond Road<br>Watseka, IL 60970 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42702<br><br>Based on interview and record review the facility failed to ensure for the dignity of two (R5, R15) of 16 residents reviewed for dignity from a total sample list of 36 residents.<br><br>Findings include:<br><br>The facility Abuse Prevention Program Policy dated 11/28/16 documents that the facility prohibits mistreatment, exploitation, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. Additionally the facility seeks to establish an environment that promotes resident sensitivity, resident security, and prevention of mistreatment, exploitation, neglect, and abuse of resident misappropriation of resident property.<br><br>1.) R5's Minimum Data Set, dated dated dated [DATE] documents that R5 is cognitively intact. R5's Minimum Data Set, dated dated dated [DATE] documents that R5 is dependent for personal hygiene.<br><br>On 8/25/26 at 12:26PM, R5 said that V12 Certified Nursing Assistant (CNA) wasn't always nice to her and could make her feel bad and hurt her feelings. R5 said that V12 CNA would get mad when R5 couldn't move her legs to help when she was being provided care. It isn't abuse, but she is very disrespectful.<br><br>2.) R15's Minimum Data Set, dated dated dated [DATE] documents that R15 is cognitively intact. R15's Minimum Data Set, dated dated dated [DATE] documents that R15 requires partial to moderate assistance with lower body cares.<br><br>On 8/27/24 at 1:10PM, R15 stated, I don't like (V12 CNA) caring for me. She has a smart mouth and she is very disrespectful to me.<br><br>On 8/26/24 at 1:28PM, V2 Director of Nursing (DON) confirmed she had complaints about (V12 CNA) and has addressed the issue. |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385<br><br>Based on interview and record review the facility failed to schedule a follow up cardiology appointment for one (R46) of two residents reviewed for dialysis in the sample list of 36.<br><br>Findings include:<br><br>R46's Diagnoses List documents R46's diagnoses include Type 2 Diabetes Mellitus, Hypertension, Chronic Obstructive Pulmonary Disease, Seizures, Stenosis of Carotid Artery, and Nonrheumatic Mitral Valve Prolapse. R46's Census documents R46 expired on [DATE].<br><br>R46's Hospital Discharge Instructions dated [DATE] documents R46's discharge problems were Acute Respiratory Failure and Hypertension, R46 has dialysis scheduled three times weekly, and to contact V27's office (Cardiologist) to schedule a follow up appointment. There is no documentation in R46's medical record that the facility contacted V27's office to schedule this appointment.<br><br>On [DATE] at 11:02 AM V11 Social Services Director stated V11 is responsible for scheduling resident appointments. V11 reviewed the facility's appointment calendar and did not see that R46 had an appointment scheduled with V27. V11 stated V11 asks for copies of hospital discharge summaries and reviews appointments that are needed. V11 stated V11 was not sure if V11 received notification to schedule R46's appointment. V11 stated V3 Assistant Director of Nursing (ADON) is the only other employee who assists with scheduling appointments.<br><br>On [DATE] at 11:07 AM V3 ADON stated the facility was probably in the process of scheduling R46's appointment, but then R46 died . V3 stated V11 does the appointment scheduling and keeps record of appointments. V3 stated V3 did not schedule R46's follow up appointment.<br><br>On [DATE] at 11:13 AM V1 Administrator stated the facility does not have a policy for scheduling resident appointments, we expect physician's orders to be followed. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42702<br><br>Based on observation, interview and record review the facility failed to obtain treatment orders and implement pressure relieving interventions for three (R5, R14 and R4) of three residents reviewed for pressure ulcer wounds from a total sample list of 36 residents.<br><br>Findings include:<br><br>The facility Preventative Skin Care Policy dated October 2006 documents that it is the policy of the facility to provide preventative skin care through repositioning and careful washing, rinsing, drying and observation of the residents skin condition to keep them clean, comfortable, well groomed and free from pressure ulcers. If reddened areas are noted, it will be reported to the Charge Nurse. Any resident identified as being at high risk for potential skin breakdown shall be turned and reposition a minimum of every two hours.<br><br>The facility Decubitus Care/Pressure Areas Policy dated January 2018 documents that it is the policy of this facility to ensure a proper treatment program has been instituted and is being closely monitored to promote the healing of any pressure ulcer.<br><br>1.) R5's skin assessment dated [DATE] documents R5 is at high risk for skin breakdown.<br><br>R5's physician orders dated 1/26/24 documents barrier cream to be applied to R5's buttocks for excoriation twice daily.<br><br>R5's August 2024 treatment administration record documents that barrier cream was not applied as ordered on 8/5/24, 8/10/24, 8/14/24, 8/17/24 and 8/20/24.<br><br>R5's Minimum Data Set, dated dated dated [DATE] documents that R5 is cognitively intact.<br><br>On 8/25/24 at 11:00AM, R5 stated she had a wound on her buttocks and legs and that she didn't think that there was a treatment on it.<br><br>On 8/26/24 at 8:36AM V2 Director of Nursing stated that she is unaware of R5 having any wounds.<br><br>On 8/26/24 at 2:15PM, R5 was rolled to the side where two half dollar sized stage two wounds were visualized on R5's right buttock and upper thigh. No dressing or treatment was on the wounds.<br><br>On 8/26/24 at 2:20PM, V16 Licensed Practical Nurse (LPN) stated she was not aware prior to now that R5 had any open areas to her skin and there were no current treatment orders for R5's open wounds.<br><br>On 8/26/24 at 2:25PM, V23 Certified Nursing Assistant (CNA) stated she saw open wounds on R5's backside last week and that she told the nurse at that time.<br><br>2.) R14's skin assessment dated [DATE] documents that R14 is at high risk for skin breakdown.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R14's orders dated 8/9/24 document to apply Nystatin External Cream 100,000 units per gram every 12 hours as needed for excoriation.<br><br>On 8/25/24 at 10:18AM, R14 stated she has a wound on her bottom. R14 was sitting in the common room from 8:30AM to 11:30AM without a pressure relieving cushion in her wheelchair.<br><br>On 8/27/24 at 10:45AM, R14 was sitting in her wheel chair in her resident room without a pressure relieving cushion in the chair.<br><br>On 8/26/24 at 8:36AM, V2 Director of Nursing stated that she is unaware of R14 having any current wounds.<br><br>On 8/26/24 at 4:15PM, R14 had open areas and irritation to inner thighs. R14's vaginal area, inner thighs and buttocks were red/raw/excoriated. A linear open wound was on the left inner thigh and a superficial open wound was on the left posterior thigh/gluteal fold.<br><br>On 8/26/24 at 4:30PM, V16 LPN stated the posterior thigh wound was identified yesterday and reported to the nurse. V12 stated R14 was red like this when she last cared for her, but couldn't recall what day.<br><br>On 8/27/24 at 1:30PM, V2 Director of Nursing stated physician orders should be followed including treatments and medications to prevent skin breakdown.<br><br>32853<br><br>3.) R4's Order Summary Report dated 8/25/24 documents diagnoses including Dementia, Shizoaffective Disorder, Type 2 Diabetes Mellitus, Muscle Weakness and Unsteadiness on Feet.<br><br>R4's Care Plan dated 2/28/24 documents R4 has a pressure ulcer or potential for pressure ulcer development with interventions to see the TAR (Treatment Administration Record) for current orders, administer treatments as ordered and monitor for effectiveness, follow the facility's policies and protocols for prevention/treatment of skin breakdown and monitor and document and report any changes in skin status all dated 2/28/24.<br><br>R4's skin risk assessment dated [DATE] documents R4 is at a high risk for skin impairment. Interventions listed on the assessment are pressure reducing device for the bed and chair and a protective device (protective sleeves). R4's Minimum Data set (MDS) dated [DATE] documents R4 has a pressure reducing device for the bed and the chair.<br><br>R4's shower sheet dated 8/4/24 documents discoloration on the left heel. R4's shower sheet dated 8/12/24 documents left heel under findings and does not document any other information regarding the left heel. R4's shower sheet dated 8/17/24 documents a pressure ulcer and has the left heel circled. R4's shower sheet dated 8/22/24 documents a blister on the left heel.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R4's Treatment Administration Record (TAR) dated 7/1/24 through 7/31/24 documents an order for cushion protective boots when in bed every shift with a start date of 7/11/24. This order is not signed out as completed on 7/12/24, 7/14/24, 7/15/24, 7/20/24, 7/25/24 and 7/26/24 on the night shift and on 7/31/24 on the day shift. There is no treatment order for the left heel on the July TAR. R4's August (TAR) documents the order for the cushion protective boots and is not signed out as completed on 8/2/24 and 8/13/24 on the day shift and on 7/3/24, 7/5/24, 7/10/24 and 7/17/24 on the night shift. R4's TAR dated 8/1/24 through 8/31/24 does not document a treatment order for R4's left heel.<br><br>On 8/25/24 at 9:10 AM, R4 was in her bed in her room with gripper socks on with her feet resting directly on the bed. There were no protective cushion boots on her feet or any boots visible in her room. On 8/26/24 at 1:46 PM and 3:25 PM, R4 was laying in bed with her feet directly on the mattress with no protective boots on her feet.<br><br>On 8/25/24 at 11:27 AM, 12:14 PM and 2:45 PM, R4 was sitting in her wheel chair and there was no cushion underneath her, she was sitting directly on the sling bottom of the wheel chair and she had gripper socks on both feet. On 8/26/24 at 8:12 AM, 8:45 AM, 9:55 AM, 11:10 AM and 1:46 PM, R4 was in her wheel chair with gripper socks on both feet and no cushion in her wheel chair underneath her.<br><br>On 8/27/24 at 1:05 PM, R4 was in bed and V23 Certified Nursing Assistant removed R4's left gripper sock. R4 had a large round sore on the left heel, approximately two inches in diameter. The bottom portion (approximately 1/4 inch) of the sore was black and necrotic. The rest of the sore was red. V23 then removed R4's right gripper sock and R4 had a red area on the right outer ankle with a white spot in the middle of the reddened area. At this time V23 confirmed that there was no cushion in R4's wheelchair that was sitting in her room.<br><br>On 8/28/24 at 9:32 AM, R4 was in bed and she did not have any protective boots on her feet.<br><br>On 8/27/24 at 11:44 AM, V2 Director of Nursing confirmed there was no treatment order for R4's left heel or right ankle.<br><br>On 8/27/24 at 1:35 PM, V3 Assistant Director of Nursing stated R4 is supposed to have protective heel boots on when she is in bed.<br><br>On 8/27/24 at 1:46 PM, V2 confirmed that R4 should have a pressure relieving device in her wheel chair and stated that they will contact the doctor to have R4's left heel looked at. |

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| F 0698<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42702<br><br>Based on interview and record review the facility failed to provide dialysis services to one (R15) of two residents reviewed for dialysis services from a total sample list of 36. This failure resulted in R15 being hospitalized for Hypervolemia.<br><br>Findings include:<br><br>On 8/27/24 at 1:10PM, R15 stated, I missed nearly two and a half months of dialysis because V11 Social Services Director didn't understand that I needed dialysis and didn't get a nurse involved. I ended up in the hospital really sick. I was doing dialysis three times a week before I came here.<br><br>R15's undated census report documents that R15 was initially admitted to the facility on [DATE].<br><br>R15's undated diagnosis sheet documents that R15 was admitted with a diagnosis of kidney failure.<br><br>R15's admission record dated 12/18/23 documents that R15 was admitted to the facility with a renal shunt for dialysis.<br><br>R15's medical record documents that R15 was admitted to the hospital on 1/30/24 for Hypervolemia.<br><br>R15's hospital discharge notes dated 2/6/24 document that R15 needs three times a week dialysis, to follow up with nephrology and to have a renal diet.<br><br>On 8/27/24 at 2:30PM, V1 administrator stated , R15 was admitted urgently in December of 2023. The day of admission R15 was supposed to have dialysis; however the facility could not provide transportation on that date and after that I'm not sure what happened because (V11 Social Services Director) was handling it (dialysis appointments).<br><br>On 8/27/24 at 2:45PM, V2 Director of Nursing said that nursing issues such as dialysis should be managed by nursing and that now they are being done so.<br><br>On 8/27/24 at 1:50PM, V32 Dialysis Registered Nurse said that R15's first treatment at their facility was on 2/9/24 after she had been being dialyzed at the hospital. V32 said that R15 has kidney failure that requires dialysis three times a week and that the risks of not receiving dialysis three times a week could result in critical fluid overload including hospitalization . |

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| F 0770<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide timely, quality laboratory services/tests to meet the needs of residents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32853<br><br>Based on interview and record review the facility failed to obtain laboratory tests as ordered and repeatedly failed to document blood glucose results for three of three residents (R4, R25, R46) reviewed for laboratory services in the sample list of 36.<br><br>Findings include:<br><br>The facility's Glucose Monitoring policy with a revised date of August 2018 documents, Purpose: To monitor resident's blood glucose to assist in the development of an appropriate medication and treatment regime for resident's with a metabolic disorder caused by an imbalance between insulin supply and demand. Document results of blood glucose and insulin dosage on medication sheet.<br><br>The facility's undated Laboratory Tests policy documents, Obtain laboratory orders upon admission, readmission and PRN (as needed) for medication and condition monitoring per the physician's order.<br><br>1.) R4's Order Summary Report documents a diagnosis of Type 2 Diabetes Mellitus with an admitted [DATE]. This Order Summary document an order for an A1C (glycated hemoglobin) every three months.<br><br>R4's pharmacy consultation report dated 6/26/24 documents R4 has orders for labs, but at the time of this review they were not available in the medical record. The missing laboratory values include: A1C every 3 months. This report is signed and dated by a physician on 7/3/24 for the recommendation to have the labs obtained.<br><br>R4's last A1C was obtained on 11/27/23, nine months ago. This laboratory report sheet was provided by V1 Administrator on 8/25/24 at 3:04 PM. The results of the A1C laboratory draw were high at 6.6% (percent) which normal range is 4.0 to 5.6.<br><br>On 8/26/24 at 11:55 AM, V3 Assistant Director of Nursing provided a laboratory report dated 7/10/24 with an A1C result of 6.7%, high again. V3 confirmed there are not any A1C results between November 2023 and July 2024, every three months as they are ordered.<br><br>40385<br><br>2.) R25's Physician Order dated 6/5/25 documents Comprehensive Metabolic Panel (CMP), Complete Blood Count (CBC) and Hepatic Function Panel. There is no documentation in R25's medical record that a Hepatic Function Panel was completed as ordered.<br><br>On 8/25/24 at 1:45 PM R25's laboratory results were viewed with V2 Director of Nursing (DON). V2 confirmed the order dated 6/5/24 included Hepatic Function Panel and confirmed there was no Hepatic Function Panel results in R25's medical record. V2 stated the Hepatic Function Panel is usually part of the CMP or Basic Metabolic Panel.<br><br>(continued on next page) |

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| F 0770<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 8/26/24 at 8:14 AM V29 Phlebotomist at facility's contracted laboratory confirmed there are additional liver function tests that are conducted as part of a Hepatic Function Panel that are not covered by a CMP. V29 stated a bilirubin level is not captured on a CMP. V2 confirmed R25 had a CBC, CMP and Lipid Panel on 6/10/24, and R25 has not had a Hepatic Function Panel completed.<br><br>3.) R46's Care Plan dated 6/24/24 documents R46 has Diabetes Mellitus and includes an intervention for blood glucose monitoring and to refer to orders and Medication Administration Record (MAR).<br><br>R46's April 2024, May 2024, and June 2024 MARs documents check blood glucose twice daily and to check blood glucose at noon four times weekly and notify the provider for blood sugar less than 60 and greater than 400. These MARs do not document R46's blood glucose results. These MARs document Lantus/Glargine insulin give 10 units daily as of 1/13/24, Jardiance 10 milligrams (mg) twice daily, and Lispro insulin 5 units subcutaneously three times daily as of 1/12/24.<br><br>On 8/26/24 11:07 AM V3 Assistant DON stated blood glucose results should be documented on the MAR. V3 reviewed R46's electronic MAR and confirmed blood glucose results were not recorded. V3 stated it must have been a computer issue. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>37813<br><br>Failures at this level require more than one deficient practice statement.<br><br>A. Based on record review and interview the facility failed to monitor potential exposure sites for Legionella. This failure has the potential to affect all 44 residents who reside in the facility.<br><br>B.) Based on observation, interview and record review the facility failed to don PPE (Personal Protective Equipment) prior to entering a contact isolation room for one of one resident (R34) reviewed for transmission based precautions in the sample list of 36.<br><br>Findings include:<br><br>a.) The Long-Term Care Facility Application For Medicare and Medicaid dated 8/25/24 documents 44 residents reside in the facility.<br><br>The facility's policy Legionella Policy and Procedures (not dated) states Legionella Bacteria thrive and multiply in hot or cold water systems and storage tanks and then spread through spray from showers and taps. Should concerns are identified the following measures may be initiated to minimize and control the risks: Have the water system inspected, maintained, and cleaned. (Annually). Ensure water cannot stagnate anywhere in the system remove redundant pipe work (As needed).<br><br>No documentation was provided by the facility to indicate the plumbing has been inspected. Locations where redundant piping may exist have been and require regular flushing have not been assessed. No surveillance has been documented.<br><br>On 8/29/24 at 10:00AM V1, Administrator stated We do not have documentation of an assessment for possible sources of stagnation or a plan to flush such sites if they exist.<br><br>32853<br><br>b.) The facility's Contact Precautions policy with a revised date of December 2009 documents, In addition to Standard Precautions, use Contact Precautions, or the equivalent for specified residents known or suspected to be infected or colonized with epidemiologicallly important microorganisms that can be transmitted by direct contact with the resident (hand or skin to skin contact that occurs when performing resident care activities that require touching the residents dry skin) or indirect contact (touching with environmental surfaces or resident care items in the residents environment.). Gloves: In addition to wearing gloves as outline under Standard Precautions, wear gloves (clean non sterile gloves are adequate) when entering the room. Remove gloves before leaving the residents environment and wash hands immediately with an antimicrobial agent or a waterless antiseptic agent. Gown: In addition to wearing a gown as outlined under Standard Precautions, wear a gown (a clean, nonsterile gown is adequate) when entering the room if you anticipate that your clothing will have substantial contact with the resident, environmental surfaces, or items in the residents room, or if the resident is incontinent or has diarrhea, an ileostomy, a colostomy, or wound drainage not contained by a dressing.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 8/25/24 at 8:48 AM, V4 Registered Nurse stated R34 is on contact isolation due to ESBL (extended-spectrum beta-lactamase, bacteria) in the urine.<br><br>On 8/26/24 at 1:31 PM, V16 Licensed Practical Nurse entered R34's room to administered medication without donning any PPE. There was a sign on the door typed up and documents Contact Isolation and to see the nurse before entering. There is no instructions as to what PPE is required prior to entering the R34's room. R34 was lying in bed and does not have fine motor control of her hands so V16 administered her medication and drink to her.<br><br>On 8/26/24 at 2:59 PM, V16 entered R34's room again without donning any PPE.<br><br>On 8/28/24 at 9:32 AM, V6 Housekeeping/Laundry Supervisor was in R34's room next to the bed showing her pictures on her phone without any PPE on.<br><br>R34's Laboratory Report dated 5/15/24 documents Urine Culture results of Klebsiella Pneumoniae ESBL and Proteus Mirabilis (bacteria). R34's Laboratory Report dated 7/19/24 documents Urine Culture results as Proteus Mirabilis and Escherichia Coli.<br><br>On 8/26/24 at 1:50 PM, V3 Assistant Director of Nursing stated that R34 is on contact isolation due to ESBL in her urine and stated that they are trying to get three negative urine cultures for her. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145389 | A. Building<br>B. Wing | 08/28/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Watseka Rehab & Hlth Care Ctr | 715 East Raymond Road<br>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 0882<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.<br><br>37813<br><br>Based on interview and record review the facility failed to employ a certified Infection Preventionist. This failure has the potential to affect all 44 residents who reside at the facility.<br><br>Findings Include:<br><br>The Long-Term Care Facility Application For Medicare and Medicaid dated 8/25/24 documents 44 residents reside in the facility.<br><br>The facility's Infection Control Surveillance and Monitoring Policy reviewed 12/7/18 states It is the policy of the facility to do routine surveillance and and monitoring of the facility to determine if compliance with work practices and care of protective clothing and equipment is maintained. Procedure: Monitoring the effectiveness of the facility work practices and protective equipment will be conducted by the Administrator, Infection Control Preventionist (ICP) and the Director of nursing (DON). This includes but is not limited to: a. Surveillance of the facility to ensure that required work practices are observed and that protective equipment and clothing are provided and properly used; b. Investigation of known or suspected parenteral exposure to blood/body fluids to establish the conditions surrounding the exposures; and c. Improve in training, work practices, or protective equipment to prevent recurrence. d. Maintain a procedure of notification to physicians, and Illinois Department of Public Health (IDPH) as required by regulation, of any infectious cases. e. Review all policies, procedures, and programs related to infection control including any environmental control on a yearly basis.<br><br>On 8/27/24 at 10:00AM V2, Director of Nursing stated I have (V3), Assistant Director of Nursing help me with Infection Prevention, tracking, and control. Neither (V3) or myself are certified Infection Preventionists.<br><br>On 8/27/24 at 10:05AM V3 stated I haven't taken the infection Preventionist training, but I track the infections, cultures and antibiotics. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 145389 | A. Building<br>B. Wing | 08/28/2024 |

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| Watseka Rehab & Hlth Care Ctr | 715 East Raymond Road<br>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.

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|---|---|
| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>40385<br><br>Based on observation, interview, and record review the facility failed to ensure a safe, comfortable, and functional environment by failing to maintain the building structure to prevent roof leaks. This failure affects one (R12) of 16 residents reviewed for environment in the sample of 36. This failure has the potential to affect all 44 residents residing in the facility.<br><br>Findings include:<br><br>On 8/25/24 at 8:09 AM near the nurse's station, centralized area where all of the resident halls connect, and the beginning of the C Hall the ceiling tiles were sagging and had large brown stains. One tile had been removed and there were cords visible hanging down approximately a couple inches below the ceiling.<br><br>On 8/25/24 at 8:20 AM R12 was lying in bed. R12's room had a brown stained ceiling tile near R12's doorway. R12 stated R12 admitted to the facility in October 2023 and the brown area on the ceiling tile has gotten larger since R12's admission. R12 stated the facility's roof leaks when it rains which is what causes the brown discoloration.<br><br>On 8/28/24 at 8:40 AM the ceiling tiles near the nurse's station and at the beginning of the C Hall were sagging and had large brown stains. One tile has been removed and had visible cords hanging down. Directly below this area was a wet floor sign and a bath towel that contained a basin collecting water droplets leaking from the ceiling.<br><br>On 8/27/24 at 3:35 PM V2 Director of Nursing stated the roof leaks and the ceiling tiles have been like that for a long time, even when V2 was working as a hospice nurse at the facility a year and a half ago.<br><br>On 8/27/24 at 3:40 PM V1 confirmed the brown, sagging ceiling tiles near the nurse's station. V1 stated the facility's roof still leaks when it rains. V1 stated the facility has gotten roof repair quotes and the roof has been patched, but it still leaks. V1 stated the roof has not been repaired yet since V1 is awaiting corporate approval of the quotes for the repair.<br><br>The Long-Term Care Facility Application For Medicare and Medicaid dated 8/25/24 documents 44 residents reside in the facility. |