STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145389	A. Building B. Wing	04/05/2023

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to notify the physician of changes in resident condition for three (R1, R2, R3) of four residents reviewed for changes in condition in the sample list of six residents. Findings include: 1.) On 4/4/23 at 8:20 AM V17 (R1's Power of Attorney) stated: V21 (R1's Family Member) visited R1 in late December 2022, assisted with dressing/incontinence care, and was concerned about R1's vaginal area. V21 reported this concern to V17 and V21 came in the next day to see R1. R1 had a grapefruit sized uterine/bladder/rectal prolapse and V17 transported R1 to the hospital. On 4/4/23 at 11:28 AM V9 CNA stated V9 noticed a golf ball sized, skin colored, cyst to the side of R1's inner labia. V9 reported this to unidentified nurses. At 1:37 PM V9 stated V9 noticed R1's cyst in the fall around August 2022. On 4/5/23 at 3:19 PM V15 CNA stated V15 assisted R1 with a shower in December 2022, and noticed what looked like a large, baseball sized hemorrhoid coming from R1's rectum. V15 reported this to an unidentified nurse. V15 had not noticed this previously during R1's showers. R1's December 2022 Physician's Orders document R1 has a diagnosis of Dementia with Behavioral Disturbances. R1's Shower/Abnormal Skin Report dated 12/29/22 signed by V15 Certified Nursing Assistant (CNA) documents R1 had redness to R1's bottom. The word hernia was written, and struck out with a line through it. There is no documentation in R1's medical record that R1's physician (V18) was notified of R1's perineal abnormalities noted in August and December 2022. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's emergency room note dated 12/29/22 at 4:08 PM documents R1 presented with a bulge in the groin that has been present for an unclear amount of time. V17 (R1's Power of Attorney) reported that R1 has complained of pain down there for months. R1's Hospital History & Physical dated 12/31/22 at 7:18 AM documents gynecology was consulted to reduce R1's vaginal prolapse and a urinary catheter was inserted with a return of 1100 cc (cubic centimeters) of urine. On 12/29/22 at 5:14 PM R1's Creatinine (kidney function laboratory test) was 2.2 (high) and R1's Blood Urea Nitrogen (BUN) (kidney function laboratory test) was 26 (high). R1 needed arrangement for pessary placement (a vaginal device that supports the uterus/bladder/rectum). R1's Abdomen/Pelvis Computed Tomography dated 12/30/22 documents R1's bladder was distended and there was a 7.8 cm (centimeter) by 8.6 cm perineal mass that was suspicious for prolapse. The impression of these results are described as, Tricompartment severe pelvic organ prolapse inferior to pubococcygeal line, causing severe bilateral right greater than left hydronephrosis (excess fluid in kidney due to urine backup) and hydroureter (enlargement of ureter caused by blockage that prevents urine from d. R1's Hospital Physician Progress Note dated 1/3/23 at 5:14 PM documents R1 was admitted with severe tricompartment pelvic organ prolapse that resulted in bilateral nephrosis causing acute kidney injury (AKI) and urinary tract infection. R1's AKI had somewhat improved, and R1's BUN was 22 and Creatinine was 1.95 on 1/3/23 at 8:24 AM. R1 was discharged on [DATE]. On 4/4/23 at 4:52 PM V2 Director of Nursing (DON) stated changes in condition and physician notification should be documented on an Assess Intervene Monitor for Wellness form or nursing note in the resident's medical record. V2 stated R1's family transported R1 to the gynecologist on 12/29/22. R1 admitted to the hospital and did not return to the facility. On 4/5/23 at 11:55 AM V2 stated V2 unable to locate any documentation regarding physician notification of R1's perineal abnormalities noted in August and December 2022. V2 was unable to locate any nursing notes for R1 between August and December 2022. On 4/5/23 at 1133 AM V18 Physician stated R1 had a history of vaginal bleeding, but does not recall that any recent vaginal problems were reported to V18 prior to R1's discharge from the facility in December 2022. R1 did not return to the facility. V18 was unsure of the reason for R1's discharge, but was told R1 admitted to another facility. 2.) On 4/4/23 at 9:02 AM 9:02 AM V7 and V8 CNAs entered R2's room and provided R2's incontinence care. R2 had a small/superficial open area on each buttock and one in the crease between R2's buttocks. V7 stated the wounds had developed within the last couple weeks. R2's Progress Note dated 3/27/23 recorded by V20 Cardiologist documents R2 reports that R2 has a sore on R2's buttocks. R2's April 2023 Physician's Orders and R2's Medication Review Report dated 4/5/23 do not document treatment orders for R2's buttock wound. There is no documentation that R2's buttock wound was reported to V19, R2's primary physician prior to 4/5/23. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's January 2023 Food and Fluid Intake Sheet documents R2's meal intake varied between 50 % and 100 %, and two entries of 25 %. R2's fluid intake varied between 240 and 480 cc (cubic centimeters) per meal. R2's February 2023 Food and Fluid Intake sheet documents R2's meal intakes averaged between 0 and 50 %. R2 refused 24 meals and fluid intake for 7 meals between 2/1/23 and 2/22/23. R3's March 2023 Food and Fluid Intake Sheet documents R2 refused 14 meals between 3/1/23 and 3/8/23. R2's fluid intake recorded on 3/1/23 was 480 cc, on 3/3/23 was 240 cc, on 3/4/23 was 360 cc, on 3/5/23 was 240 cc, on 3/6/23 was 0, and 3/7/23 was 120 cc. There is no documentation in R2's medical record that V19 Physician was notified of R2's poor fluid/meal intakes in February prior to being hospitalized on [DATE] and in March 2023 prior to being hospitalized on [DATE]. R2's Nursing Note dated 3/5/23 during 6:00 PM - 6:00 AM shift, documents R2 had poor intake, complained of chest pain, vomited a small amount and Nitroglycerine was administered. This note does not document that V19 was notified. On 4/4/23 at 11:38 AM V10 Certified Nursing Assistant (CNA) stated in the beginning of March 2023, R2 was not eating/drinking very much, and the nurses and V2 Director of Nursing were aware. On 4/4/23 at 2:13 PM V2 DON reviewed R2's February and March 2023 fluid/meal intakes and confirmed R2's refusals and poor intakes. V2 sated the nurses should have notified the physician of R2's poor appetite/fluid intakes. At 4:52 PM V2 stated changes in condition and physician notification should be documented on an Assess Intervene Monitor for Wellness form or nursing note in the resident's medical record. On 4/5/23 at 8:11 AM V2 stated V2 was unable to locate documentation that V19 was notified of R2's poor fluid/meal intakes and vomiting on 3/5/23. At 9:00 AM V2 stated V2 was not aware that R2 had open wounds to R2's buttocks, and R2 had a buttock wound that healed in March. V2 confirmed when wounds are identified the physician should be notified to obtain a treatment order. On 4/5/12 at 10:13 AM V19 Physician stated R2's potassium was 2.4 on 2/22/23. The facility notified V19 of R2's behaviors, but V19 does not recall being notified of R2's poor appetite and fluid intake. R2's hospitalization s (2/22/23 and 3/8/23) definitely could have been prevented if the facility had notified V19 of R2's decreased intakes and vomiting. 3.) On 4/4/23 at 4:42 PM R3 stated R3 went to the hospital in March 2023 for pneumonia. R3 had a cough that started a few days prior to that, and then the nurses decided R3 needed to go to the hospital. On 4/4/23 at 12:01 PM V7 CNA stated a few days prior to R3 being hospitalized , R3 had a cough as if R3 was trying to clear phlegm. On 4/5/23 at 8:44 AM V13 CNA stated R3 had a cough, was short of breath, requested R3's oxygen be applied, and was using a wheelchair instead of walking with a walker a few days prior to R3 going to the hospital on 3/5/23. V13 reported this to an unidentified nurse. R3's Nursing Note dated 3/5/23 at 1:45 PM documents R3 was short of breath and lungs were coarse. The last recorded nursing note prior to 3/5/23 is dated 1/17/23. Thre is no documentation in R3's medical record that R3's physician was notified of any respiratory changes until 3/5/23. On 4/5/23 at 11:33 AM V18 Medical Director/Physician stated If a resident develops a cough, the nurse should examine the resident for fever, shortness of breath, assess lung sounds, and notify the physician so a Completed Blood Count and Complete Metabolic Profile (laboratory values) and chest x-ray can be ordered. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/4/23 at 4:52 PM V2 DON stated changes in condition and physician notification should be documented on an Assess Intervene Monitor for Wellness form or nursing note in the resident's medical record. On 4/5/23 at 8:11 AM V2 stated V2 was unable to locate documentation that R3's physician was notified of R3's cough prior to 3/5/23. The facility's Notification for Change in Resident Condition or Status dated as revised 12/7/17 documents: The resident's physician will be notified when a resident has a change in physical/emotional/mental condition, a need to alter medical treatment and symptoms of infection. Information related to a resident's change in condition will be recorded in the resident's medical record.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to monitor and assess residents, timely identify and report changes in condition, and follow physician's orders for two of four residents (R2, R3) reviewed for change in condition in the sample list of six residents. This failure resulted in R2 having multiple hospitalization s for dehydration and acute kidney injury, and R3 being hospitalized for six days with pneumonia. Findings include: 1.) R2's March 2023 Physician's Orders Summary documents: R2 admitted to the facility on [DATE]. R2's diagnoses include Dehydration, Acute Kidney Injury, Hypertension, Coronary Artery Disease with stable Angina Pectoris, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease Stage III, and systolic/diastolic Congestive Heart Failure. R2's Minimum Data Set (MDS) dated [DATE] documents R2 has moderate cognitive impairment, requires limited assistance of two staff for eating, and has not had complaints of difficulty or pain with swallowing. R2's Care Plan dated 2/1/23 documents R2 is at risk for altered nutritional status with an intervention to record meal intakes and report changes in R2's usual patterns. R2's laboratory results dated [DATE] at 12:47 PM documents R2's potassium was 3.4 and Creatinine (kidney function laboratory test) was 1.3. R2's January 2023 Food and Fluid Intake Sheet documents R2's meal intake varied between 50 % and 100 %, and two entries of 25 %. R2's fluid intake varied between 240 and 480 cc (cubic centimeters) per meal. R2's February 2023 Food and Fluid Intake sheet documents R2's meal intakes averaged between 0 and 50 %. R2 refused 24 meals and fluid intake for 7 meals between 2/1/23 and 2/22/23. R3's March 2023 Food and Fluid Intake Sheet documents R2 refused 14 meals between 3/1/23 and 3/8/23. R2's fluid intake recorded on 3/1/23 was 480 cc, on 3/3/23 was 240 cc, on 3/4/23 was 360 cc, on 3/5/23 was 240 cc, on 3/6/23 was 0, and 3/7/23 was 120 cc. There is no documentation in R2's medical record that V19 was notified of R2's poor fluid/meal intakes in February prior to being hospitalized on [DATE] and in March 2023 prior to being hospitalized on [DATE]. R2's February 2023 Medication Administration Record (MAR) documents R2 received the following: Bumetanide (Bumex) (diuretic) 2 mg (milligrams) by mouth twice daily from 2/1-2/21/23, on 2/24/23, and 2/26/23-2/27/23. Acetazolamide (diuretic) 500 mg by mouth twice daily, and Eplerenone (diuretic) 25 mg by mouth daily. R2's Nursing Notes document the following: On 2/22/23 at 11:00 AM R2's potassium level was 2.4 (low). V19 Physician evaluated R2 and ordered for R2 to be transferred to the local emergency room . On 3/1/23 at 12:05 AM R2 complained of chest pain, vomited, and was transferred to the emergency room . R2 returned at 7:50 AM with diagnosis of gastroenteritis, low potassium and elevated Troponin level. R2 was given intravenous potassium at the hospital. On 3/5/23 during 6:00 PM - 6:00 AM shift, R2 had poor intake, complained of chest pain, vomited a small amount and Nitroglycerine was administered. This note does not document that V19 was notified. On 3/8/2 during 6:00 AM - 6:00 PM shift, R2 complained of chest pain, V19 was notified, and R2 was transferred to the local hospital. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R2's Progress Note by V19 dated 2/23/23 documents R2 had mental status change, loss of appetite, hypokalemia (low potassium), and dehydration. V19 advised to send R2 to the hospital. R2's Hospital Discharge Summary dated 2/24/23 documents: R2 was admitted to the hospital on 2/22/23 and rehydrated by intravenous therapy, diuretics were held, and potassium was administered. This corrected R2's acute on chronic renal failure. R2 had acute dehydration that contributed to acute on chronic kidney failure with Creatinine (kidney function laboratory test) of 2.01 (high). R2's potassium was 2.6 (critically low). Discharge instructions include assessing diuretic therapy for acute hypokalemia cause, as R2's potassium has been corrected to 3.5 or higher (normal range), and orders for Bumetanide 2 mg by mouth once daily - hold if not eating/drinking. R2's After Visit Hospital Summary dated 3/2/23 documents: R2 was diagnosed with gastroenteritis and instructions to stay hydrated, take Zofran for nausea, and to follow up with R2's physician. Administer Zofran 4 mg (milligrams) by mouth as needed every 8 hours for nausea/vomiting for up to 15 doses. R2's March 2023 MAR does not document that Zofran was administered. This MAR documents Bumetanide was given daily from 3/2/23-3/8/23 and not held as ordered when R2's intake was poor and refusing meals between 3/1/23 and 3/8/23. There is no documentation in R2's medical record that R2's blood pressure was routinely monitored twice daily in February and March 2023. R2's Hospital History & Physical dated 3/8/23 documents: R2 presented with hypotension (low blood pressure) and Acute Kidney Injury likely secondary to dehydration. R2 received intravenous fluids for hydration and R2's diuretics were held. R2 reported having chest pain for the last week, nausea and vomiting, and pain with swallowing food. R2 reported avoiding drinking water due to the pain. R2 had previously admitted to the hospital for dehydration on 1/17/23. R2's blood pressure in the emergency room was 90/60. On 4/4/23 at 11:38 AM V10 Certified Nursing Assistant (CNA) stated in the beginning of March 2023, R2 was not eating/drinking very much, and the nurses and V2 Director of Nursing were aware. On 4/5/23 at 9:06 AM V16 CNA stated R2 had a poor appetite and fluid intake was poor in February and March 2023. R2 transferred R2's self when R2 first admitted , and then started sleeping a lot more and requiring a full mechanical lift to transfer. R2 had vomited last month on an unknown date. V16 reported R2's poor intakes and vomiting to an unidentified nurse. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 4/4/23 at 2:13 PM V2 Director of Nursing (DON) reviewed R2's February and March 2023 fluid/meal intakes and confirmed R2's refusals and poor intakes. V2 sated the nurses should have notified the physician of R2's poor appetite/fluid intakes. V2 stated R2 was transferred to the hospital on 3/2/23 for nausea/vomiting/diarrhea. V2 confirmed R2's 3/2/23 discharge instructions recommended to administer Zofran as needed for nausea/vomiting, and confirmed Zofran was not administered prior to V2's hospitalization on [DATE]. At 4:52 PM V2 stated changes in condition and physician notification should be documented on an Assess Intervene Monitor for Wellness form or nursing note in the resident's medical record. V2 stated vital signs should be done twice daily and documented on a log kept in a binder at the nurse's station. On 4/5/23 at 8:11 AM V2 stated V2 was unable to locate documentation that V19 was notified of R2's poor fluid/meal intakes or vomiting on 3/5/23. On 4/5/23 at 10:47 AM V2 stated V2 was unable to locate any vital sign logs for R2 in February and March 2023. At 11:55 AM V2 stated the nurses should have followed the physician's order to hold Bumex when R2 had poor intakes. On 4/5/12 at 10:13 AM V19 Physician stated R2's potassium was 2.4 on 2/22/23. The facility notified V19 of R2's behaviors, but V2 does not recall being notified of R2's poor appetite and fluid intake. V2 would have ordered labs and intravenous fluids if needed if V19 was notified. R2 was seen in the emergency roiagnom on [DATE] for gastroenteritis. If R2 was not eating and had nausea/vomiting, the facility should not have given R2's diuretics which would make R2 dry as a bone. The facility should have held R2's diuretic and notified V19. Diuretics make a person even drier, especially if they are not drinking. V19 evaluated R2 on 2/23/23 and R2 did not look good. R2 looked dehydrated and had altered mental status. V19 instructed the facility to transfer R2 to the hospital. Lack of appetite with poor food/fluid intake and vomiting causes decreased potassium levels and affects kidney function. R2's hospitalization s definitely could have been prevented if the facility had notified V19 of R2's decreased intakes and vomiting. The nursing home staff should have followed the Bumex order to hold when R2's intakes were poor. The facility also should have been monitoring R2's blood pressures closes, as low blood pressure indicates dehydration. They should have been obtaining R2's vitals more frequently once R2's intakes were poor. 2.) R3's Hospital Discharge Summary documents R3 admitted to the hospital on 3/5/23 with Pneumonia and discharged on [DATE]. R3 received aggressive antibiotic therapy, pulmonary toileting, and chest physiotherapy to help clear secretions. R3's Hospital Progress Note dated 3/6/23 documents R3's chief complaint was cough and increased difficulty breathing over the last 2-3 days. R3 had a loose sounding cough that R3 reported having for an unknown period of time. R3's Nursing Note dated 3/5/23 at 1:45 PM documents R3 was short of breath and lungs were coarse. The last recorded nursing note prior to 3/5/23 is dated 1/17/23. There is no documentation in R3's medical record that R3's lungs were assessed and vital signs obtained between 3/1/23 and 3/5/23. On 4/4/23 at 4:42 PM R3 stated R3 went to the hospital in March 2023 for pneumonia. R3 had a cough that started a few days prior to that, and then the nurses decided R3 needed to go to the hospital. On 4/4/23 at 12:01 PM V7 CNA stated a few days prior to R3 being hospitalized , R3 had a cough as if R3 was trying to clear phlegm. On 4/5/23 at 8:44 AM V13 CNA stated R3 had a cough, was short of breath, requested R3's oxygen be applied, and R3 was using a wheelchair instead of walking with a walker a few days prior to R3 going to the hospital on 3/5/23. V13 reported this to an unidentified nurse. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 4/5/23 at 11:33 AM V18 Medical Director/Physician stated: If a resident develops a cough, the nurse should examine the resident for fever, shortness of breath, assess lung sounds, and notify the physician so a Completed Blood Count and Complete Metabolic Profile (laboratory values) and chest x-ray can be ordered. On 4/4/23 at 4:52 PM V2 DON stated changes in condition and physician notification should be documented on an Assess Intervene Monitor for Wellness form or nursing note in the resident's medical record. V2 stated vital signs should be done twice daily and are documented on a log kept in a binder at the nurses' station. Vital signs are not documented in the resident's medical record routinely. On 4/5/23 at 11:55 AM V2 DON stated when a resident has a cough the nurses should assess lung sounds and pulse oximetry, and notify the physician. The facility's Notification for Change in Resident Condition or Status dated as revised 12/7/17 documents: The resident's physician will be notified when a resident has a change in physical/emotional/mental condition, a need to alter medical treatment and symptoms of infection. Information related to a resident's change in condition will be recorded in the resident's medical record.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to provide incontinence care during toileting assistance for one resident (R3) of three reviewed for incontinence care in the sample list of 6. Findings include: R3's Minimum Data Set, dated dated dated [DATE] documents R3 has severe cognitive impairment, requires limited assistance of one staff person for toileting, and is frequently incontinent of urine and occasionally of bowel. R3's Hospital Discharge Summary dated 3/5/23 documents R3 was admitted to the hospital on 3/5/23 and diagnosed with an acute urinary tract infection with Escherichia coli (bacteria commonly found in colon.) On 4/4/23 at 4:33 PM V14 Certified Nursing Assistant entered R3's room and offered to assist R3 with toileting. R3 walked to the bathroom and transferred onto the toilet. R3's incontinence brief was wet with a large amount of urine. V14 removed the brief and removed V14's gloves. V14 left the room to obtain a clean brief, and instructed R3 to pull the call light. V14 returned and applied a clean brief. R3 stood from the toilet and V14 instructed R3 to pull up R3's brief/pants. V14 did not cleanse R3's perineal area/buttocks. R3 had a small pea sized open area to R3's right inner buttocks. On 4/4/24 at 4:45 PM V14 confirmed V14 did not cleanse R3's perineal area. V14 stated V14 usually uses rags for cleansing during incontinence care. On 4/4/23 at 4:52 PM V2 Director of Nursing stated if the resident is incontinent, staff should cleanse the resident's perineal area during toileting. The facility's Perineal Cleansing policy with a reviewed date of December 2017 documents: Perineal cleansing is done to eliminate odor, prevent irritation/infection, and for the resident's self-esteem. Wash, rinse, and dry the pubic area, inner thighs, and frontal perineum followed by the peri-anal area after incontinence and prior to applying a clean brief.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to maintain complete and accurate medical records for four of six residents (R1, R2, R3, R6) reviewed for change in condition in the sample list of six. Findings include: 1.) On 4/4/23 at 11:28 AM V9 CNA stated R1 noticed a skin colored golf ball sized cyst to the side of R1's inner labia, and V9 reported this to an unidentified nurse. At 1:37 PM V9 stated V9 noticed R1's labia cyst in the fall around August 2022. On 4/4/23 at 3:19 PM V15 CNA stated: V15 noticed what appeared to be a large, baseball sized, hemorrhoid coming out of R1's rectum while bathing R1 in December 2022. V15 had not noticed the hemorrhoid prior to that day and notified an unidentified nurse. R1's closed medical record was reviewed and did not contain any documentation of the labial cyst noted in August 2022 or nursing notes between August 2022 and December 2022. R1's Shower Sheet dated 12/29/22 and signed by V15 Certified Nursing Assistant (CNA) documents R1 had redness to R1's bottom. There is no follow up documentation regarding this, that R1's family transported R1 to the hospital, or the reason for the hospital transfer in R1's medical record. On 4/4/23 at 1:48 PM V2 Director of Nursing (DON) stated the nurses should be documenting when there are changes in resident's condition. V2 would like to see a nursing note charted at least monthly. At 2:13 PM V2 stated the nurses are not always good about documenting when they notify the physicians. On 4/5/23 at 8:11 AM V2 stated: R1 had vaginal bleeding in 2021 and V20 Social Services transported R1 to the gynecologist. R1 refused to get out of the vehicle to go inside to be evaluated. We involved the family about R1's gynecologist appointment. R1's family took R1 to the gynecologist in December 2022 and then R1 was transferred to the hospital. R1's family was not willing to take R1 to the gynecologist prior to December 2022. V2 has not been able to locate any documentation in R1's medical record of this information or any nursing notes between August 2022 and December 2022. At 11:55 AM V2 stated the facility has been having problems with locating medical records after corporate staff have thinned charts and when records are sent to storage. 2.) R2's Nursing Note dated 2/22/23 at 11:00 AM documents V19 Physician was in the facility, evaluated R2, and ordered for R2 to be sent to the hospital. R2's Nursing Note dated 2/23/23 6:00 PM-6:00 AM shift (no specific time) documents: R2 readmitted to the facility from the hospital. R2's Nursing Note dated 3/5/233 6:00 PM-6:00 AM shift (no specific time) documents R2 complained of chest pain and had vomited. Nitroglycerine was administered. R2's Nursing Note dated 3/7/23 6:00 AM-6:00 PM (no specific time) documents R2 complained of chest pain, R2's vitals were assessed, and V19 Physician was notified. R2's Nursing Note dated 3/8/23 6:00 AM-6:00 PM (no specific time) documents R2 was transferred to the hospital per V19's orders for complaints of chest pain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145389	A. Building B. Wing	04/05/2023

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R2's medical record does not contain progress notes for V19's visits on 2/23/23 and 1/26/23, and V20 Cardiologist consult on 3/27/23. The facsimile cover sheets dated 4/5/23 documents these physician visit notes were sent to the facility on [DATE]. R2's Cardiology Progress Note dated 3/27/23 documents: R2 was hypotensive (low blood pressure) due to decreased oral intake and diuretic use, monitor R2's blood pressure closely and monitor for signs of hypervolemia (fluid retention). R2's medical record does not document vital signs were routinely monitored twice daily in February, March, and April 2023. On 4/4/23 at 1:48 PM V2 DON stated the nurses should be documenting a time on their nursing notes, and agency nurses think they can enter a shift for their nursing note entry time. On 4/4/23 at 4:52 PM V2 DON stated vital signs should be documented twice daily, but they aren't always completed. Vitals are recorded on a log kept in a binder at the nurse's station and not in the resident's medical record. On 4/5/23 at 11:55 AM V2 confirmed R2's physician visit notes from 1/26/23, 2/23/23, and 3/27/23 were not in R2's medical record prior to 4/5/23 when the facility contacted the physicians' offices to request copies of these records. 3.) R3's March 2023 Physician's Orders and April 2023 Medication Review Report lists R3's physician as V18. R3's Nursing Note dated 3/5/23 at 1:45 PM documents R3 was short of breath and lungs were coarse. The last recorded nursing note prior to 3/5/23 is dated 1/17/23, and there is no documentation that R3 had a cough noted prior to 3/5/23. R3's Nursing Note dated 4/3/23 6:00 AM-6:00 PM (no specific time) documents R3 had a change in skin to left buttocks that measured 0.2 centimeters by 0.5 centimeters, the physician was notified and order was received to apply barrier cream twice daily and as needed. This order was not transcribed to R3's Treatment Administration Record or Physician's Orders. On 4/4/23 at 4:42 PM R3 stated R3 went to the hospital in March 2023 for pneumonia, and R3 had a cough that started a few days prior to that. R3 stated R3's bottom started hurting a few days ago, a nurse and CNA assessed R3 and found an open sore. R3 stated staff have been applying cream to the area, but none was applied today. On 4/4/23 at 12:01 PM V7 CNA stated a few days prior to R3 being hospitalized , R3 had a cough as if R3 was trying to clear phlegm. On 4/5/23 at 11:33 AM V18 Physician stated: R3 is not V18's patient. Sometimes the facility has V18 listed incorrectly in the medical record as a resident's physician and V18 has to tell the facility to correct it. On 4/5/23 at 10:47 AM V2 DON confirmed there are no documented treatment orders and treatment administrations for R3's buttock wound on April 2023 Treatment Administration Records and Physician's Order Summaries. At 11:55 AM V2 stated R3's physician is V19. 4.) R6's Nursing Note dated 3/14/23 6:00 AM-6:00 PM (no specific time) documents R6 was lethargic and hard to arouse during morning medication administration, and had some facial asymmetry noted. R6's physician and family were notified and R6 was transferred to the local hospital. (continued on next page)

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	145389	A. Building B. Wing	04/05/2023

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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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/4/23 at 1:48 PM V2 DON stated the nurses should be documenting a time on their nursing notes, and agency nurses think they can enter a shift for their nursing note entry time. The facility's General Rules of Charting/Documentation dated as revised January 2005 documents: Every entry must have the date (month, day and year), time, and your signature following the entry. Chart all pertinent changes in the resident's condition. Frequency of progress note charting: a. New Admission/Re-Admission: progress noted per facility policy (minimum of 72 hours). b. Change in resident's status: mental/physical, every shift until stabilized, 24 hour minimum. c. New problem identified: every shift until resolved or stabilized. d. Routine notes: per facility policy regarding Medicare, etc. (etcetera) However, every resident must have a note by a licensed nurse at least monthly. Any vital signs other than monthly are to be documented in the nurse's notes.