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	05/18/2023

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 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** 35510 Based on interview and record review, the facility failed to provide treatment and services to promote wound healing for a resident. R1 was admitted to the facility with multiple burn wounds to R1's right front thigh, left front thigh, left rear knee, left rear lower leg, and back in which the facility failed to assess, monitor, obtain orders and provide treatments for R1's wounds. This failure affects one of three residents (R1) reviewed for wounds on the sample of five. These failures resulted in R1's open wounds on R1's back to deteriorate and become infected requiring hospitalization . Findings include: The facility's Skin Condition and Monitoring policy dated 3/16/23 documents it is the policy of the facility to provide proper monitoring, treatment, and documentation of any resident with skin abnormalities. This policy documents the nurse will assess and document the findings in the nurses notes and complete a skin evaluation. The nurse will then notify the physician and obtain a treatment order including type of treatment, location of area to be treated, frequency of treatment and cleansing of the wound. Any skin abnormality will have a specific treatment order until area is resolved. Documentation of the skin abnormality must occur upon identification and at least weekly thereafter until the area is healed. Documentation of the area must include size, shape, depth, odor, color and presence of granulation tissue or necrotic tissue, treatment and response to treatment and prevention techniques in place for the resident. R1's Hospital Discharge Skin/Wound Assessments dated 4/7/23 at 8:00am document the R1's burn wounds including burn wounds to the Left posterior thigh and Back. These wound assessments document R1's dressing changes to each of these wounds as being changed on 4/6/23 and were dry and intact. R1's Admission/Readmission Nursing Evaluation dated 4/7/23 at 3:46pm documents R1 admitted to the facility with reason for admission as Tracheostomy care, wound care and an indwelling urinary catheter. This evaluation documents R1 has burn wounds to the right front thigh, left front thigh, left rear knee and left rear lower leg with measurements. There is no documentation of R1's multiple back wounds on admission to the facility. This evaluation documents R1 is alert and oriented to person, place, time and situation and communicates via communication board. (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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R1's Electronic Clinical Physician Orders dated 5/18/23 at 6:10pm do not document orders for wound care/dressing changes for April 2023 and May 2023. R1's Electronic Treatment Administration Records (TAR) dated April 2023 and May 2023 do not document R1 received dressing changes to R1's multiple burn/skin graft wounds on R1's back or any other of R1's burn/skin graft wounds, including R1's lower extremities. There is no documentation of attempts by the facility to clarify/review post hospital visit needs for R1's wound treatments. R1's Hospital records document R1's wound counsult note for multiple wounds present on admission 4/11/23 and wound details as follows: 4/11/23 at 11:42pm, R1's lower thoracic spine wound was midline lower thoracic spine with partial thickness. The wound bed was clean, moist, pink. Periwound was scar tissue with a scant amount of serosanguineous drainage. 4/12/23 at 12:00am, R1's left scapula multiple wound beds were clean, moist, and pink. The periwound was scar tissue and A scant amount of serosanguineous drainage. 4/12/23 at 12:00am, R1's right scapula multiple wound beds were clean, moist, and pink. The periwound was scar tissue With a scant amount of serosanguineous drainage. 4/12/23 at 12:00am, R1's multiple Left posterior leg wounds extending up to the posterior knee learned about was clean moist and pink with periwound of scar tissue. This wound contained a scant amount of serosanguineous drainage. 4/12/23 at 12:00am, R1's Right abdomen wound bed was clean with red hypergranulation and sutures, multiple areas. Red granulation was 76 to 100%. peri-wound is documented as scar tissue and that these wounds had small amount of serosanguineous drainage. This was cleansed with sterile normal saline and a border dressing applied. 4/12/23 at 12:00am, left lateral hip multiple wound beds were clean, dry, pink. peri-wound is documented as scar tissue with no drainage. 4/12/23 at 10:05am, left second toe dorsal pressure injury deep tissue and present on admission. The wound bed is dry and maroon and purple and color. peri-wound is intact with no drainage. 4/12/23 Left dorsal thigh multiple wound beds are clean, moist, and pink with no drainage and peri-wound as scar tissue. 4/12/23 at 10:09am, right thigh medial multiple wound beds clean, moist, pink with peri-wound documented as scar tissue and contained a scant amount of serosanguineous drainage. 4/12/23 at 10:10am, left lower back wound had full thickness with wound bed moist, pink, with slough. Red/granulation tissue 1-26%, yellow slough 51-75% with the peri-wound documented as scar tissue with a small amount of serosanguineous drainage. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R1's Hospital Discharge Summary documents R1 discharged from the hospital on 4/25/23. This summary does not document wound care orders for R1's multiple wounds. R1's Hospital Discharge Instructions dated 4/25/23 do not document wound care/dressing change orders for R1' multiple wounds on R1's body. There is no documentation in R1's electronic medical record that the facility requested or obtained wound care orders upon readmission to the facility for R1's multiple wounds on multiple areas of R1's body. R1's Admission assessment dated [DATE] at 11:58am documents R1 readmitted to the facility on [DATE]. This assessment documents R1's admitting diagnosis as Respiratory Failure with reason for admission, tracheostomy. This assessment does not document R1's multiple skin wounds to R1's body. On 5/10/23 at 2:35pm, V5, emergency room Physician stated R1 admitted to the hospital on 5/3/23 with non-healing wounds and required a lot of cares/frequent wound care. V5 stated R1 is at an increased risk for skin breakdown as well as infection/decline to R1's wounds due to R1's history of burn wounds with skin grafts and current open wounds. R1's Hospital Nursing notes dated 5/3/23 at 9:55pm document R1 has poor skin turgor with breakdown, wounds with wound odor. These notes documents R1 has multiple open wounds to R1's back and legs bilaterally in area of previous burned skin. This note documents R1's dressings on R1's wounds were dated 4/27/2023 with purulent drainage noted. This note documents R1 has multiple dressings on legs, back and abdomen that were dated 4/27/2023. R1's wound dressings to R1's left hip, back, left thigh were draining yellow thick sanguineous and purulent drainage and had a foul odor. This note documents these dressings were soaked off with normal saline soaks, R1's wound dressings were removed and R1's wound beds were denuded with sanguineous, yellow thick green drainage noted in wound beds with a foul odor to R1's wounds. This note documents V12, R1's family stated R1's wounds were not that severe prior to admission to the facility. This note also documents 90% of R1's back is covered in full thickness open wounds with sanguineous drainage. R1's Hospital Therapy Notes dated 5/4/23 at 3:44pm document R1 has several open wounds from his previous burn injuries that have not been properly cared for and are infected. these notes document R1 would be appropriate to return to a skilled nursing facility, however it does not appear that (R1's) current facility has been able to provide the quality of care needed by (R1.) R1's Wound Consult note signed by V9, Wound Physician/General Surgeon dated 5/8/23 documents R1 has multiple raw areas on the back and behind the thigh that are still bleeding and that R1 needs to have operation on R1's wounds with potential skin grafts to wounds. On 5/10/23 at 1:00pm, V8, Licensed Practical Nurse (LPN)/Case Manager stated V9, Wound Physician/General Surgeon had recommended R1 go to surgery for skin grafting to R1's wounds. V8 was unsure if wound cultures were obtained but that V8 observed R1's wounds and they had slough and appeared infected. V8 stated when R1 came back to the hospital on 5/3/23, R1's wounds smelled awful and the worst V8 has ever seen. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 5/18/23 at 3:25pm, V2, Director of Nursing (DON) stated when R1 initially admitted to the facility on [DATE], R1 had fine mesh gauze impregnated with a blend of 3% Bismuth Tribromophenate and petrolatum to R1's wounds to R1's legs including R1's front left thigh, left posterior knee, left lower posterior leg and R1's right thigh. V2 stated those dressings were removed and replaced. V2 stated R1 could not tolerate facility staff holding R1's leg up to wrap, so V2 tried to do (internet search engine) search to find a dressing that would not stick to R1's wounds. V2 stated R1's leg wounds had some serosanguinous drainage but no odor and R1's wounds did not appear infected on 4/7/23. V2 stated, normally don't change (wound dressings) for 3-5 days but R1 did not have orders when R1 admitted to the facility and R1 did not have wound dressings to R1's back or any open areas. V2 stated V2 completed the assessment of R1's skin and R1 had wounds to the thigh, back of knee, but not R1's back. V2 stated V2 and an additional staff member who V2 was unable to identify slightly turned R1 over to get to R1's leg but that V2 did not complete a full skin assessment to R1's back. V2 stated R1 had orders for fine mesh gauze impregnated with a blend of 3% Bismuth Tribromophenate and petrolatum and that these orders were on R1's paperwork. V2 stated R1's electronic Clinical Physician Orders should document the wound care orders but do not. V2 stated V2 thought V2 put in R1's orders related to wound care/dressing changes, but (V2) working pretty late. V2 confirmed R1's wound care/dressing change orders were not entered in to R1's electronic medical record. V2 stated, looks like a partial skin assessment was completed when R1 readmitted to the facility on [DATE], but no detailed wound assessment. V2 stated V2 documented R1 had open burn wounds and asked staff (unsure of names of staff) to go back and document what staff found because V2 had other things to get done. V2 stated, Apparently I did not do a thorough (skin) assessment (on 4/7/23) if (V2) didn't see the wounds on (R1's) back.V2 stated V2 does not see documentation nor is V2 aware of any wound dressing changes being completed to R1's back while R1 was a resident at the facility.

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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. 35510 Based on interview and record review, the facility failed to ensure urinary catheter care was completed for three of three residents (R1, R3, R4) reviewed for urinary catheters on the sample of five. Findings include: The facility's Catheter Care policy dated 3/15/23 documents catheter care is provided daily and as needed to all residents who have an indwelling catheter to reduce the incidence of infection. This policy documents staff are to wash their hands and apply clean gloves and wash the perineal area and if a male, retract the foreskin to wash around the urinary meatus. The facility's Intake and Output Measurement policy dated 3/20/23 documents the policy is to provide an accurate account of the resident's fluid intake and output. This policy documents to measure and record all intake and output including urine and drainage from catheter tubes. 1. R1's Physician's Orders dated 5/18/23 do not document orders for R1's urinary catheter or orders for urinary catheter care. R1's Care Plan Screen Admission/Baseline dated 4/7/23 documents R1 has a urinary catheter but does not document a plan of care related to R1's urinary catheter use. R1's Treatment Administration Records (TAR) dated April 2023 and May 2023 do not document R1 received urinary catheter care while at the facility. There is no documentation the facility was measuring and recording R1's urinary catheter output. On 5/18/23 at 3:25pm, V2, Director of Nursing stated urinary catheter care is to be completed every shift and as needed including emptying the urinary catheter bag once a shift and as needed. V2 stated the urinary catheter care completion is documented on the residents TAR and Certified Nursing Assistants (CNA's) have access to chart the amount of output from the urinary catheters. V2 stated V2 was unable to find documentation of amount of output from R1's urinary catheter or that R1 received urinary catheter care while at the facility. 2. R3's Care Plans dated 11/21/22 document R1 requires an indwelling urinary catheter for Urinary Retention. These care plans document R1's Urinary Catheter size as 18 french with a 30cc (cubic centimeters) balloon. These care plans document to complete urinary catheter care twice daily with soap and water, monitor/record changes in urinary output and empty urinary collection bag every shift and as needed. R3's Electronic Treatment Administration Records (TAR) dated April 2023 and May 2023 document R3 is to receive urinary catheter care every shift. These TAR's do not document R3 received urinary catheter care as follows: April 2023 TAR: Day shift: 4/6/23, 4/17/23, 4/18/23, 4/27/23, 4/28/23. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Night shift: 4/6/23, 4/7/23, 4/13/23, 4/16/23, 4/20/23, 4/21/23, 4/27/23, 4/29/23, 4/30/23. May 2023 TAR: Day shift: 5/1/23, 5/6/23, 5/7/23, 5/10/23, 5/12/23. Night shift: 5/4/23, 5/12/23, 5/13/23, 5/14/23. There is no documentation the facility was measuring and recording R3's urinary catheter output. On 5/18/23 at 3:25pm, V2, Director of Nursing stated urinary catheter care is to be completed every shift and as needed including emptying the urinary catheter bag once a shift and as needed. V2 stated the urinary catheter care completion is documented on the residents TAR and Certified Nursing Assistants (CNA's) have access to chart the amount of output from the urinary catheters. V2 stated V2 was unable to find documentation of amount of output from R3's urinary catheter. 3. R4's Physician's Orders dated 4/4/23 document R4 is to receive urinary catheter care every shift. R4's Care Plans dated 4/4/23 document R4 requires an indwelling urinary catheter for a diagnosis of Multiple Sclerosis, Neurogenic Bladder and Pressure Ulcers. These care plans document staff are to complete urinary catheter care twice daily with cares with soap and water. These care plans also document to monitor intake and output every shift and to empty urinary catheter collection bag every shift and as needed. There is no documentation R4's urinary catheter collection bag is being emptied or that output from the urinary catheter is being monitored/documented. R4's Electronic Treatment Administration Records (TAR) dated April 2023 and May 2023 document R4 is to receive urinary catheter care every shift. These TAR's do not document R4 received urinary catheter care as follows: April 2023: Day shift: 4/10/23, 4/11/23, 4/13/23, 4/14/23, 4/18/23, 4/20/23, 4/21/23, 4/23/23, 4/25/23, 4/26/23. Night shift: 4/4/23, 4/6/23, 4/22/23, 4/26/23, 4/29/23. May 2023: Day shift: 5/1/23, 5/2/23, 5/3/23, 5/6/23, 5/8/23, 5/9/23, 5/10/23, 5/11/23, 5/12/23. Night shift: 5/6/23, 5/10/23, 5/13/23, 5/14/23. On 5/18/23 at 3:25pm, V2, Director of Nursing stated urinary catheter care is to be completed every shift and as needed including emptying the urinary catheter bag once a shift and as needed. V2 stated the urinary catheter care completion is documented on the residents TAR and Certified Nursing Assistants (CNA's) have access to chart the amount of output from the urinary catheters. V2 stated V2 was unable to find documentation of amount of output from R4's urinary catheter.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 35510 Based on interview and record review, the facility failed to ensure residents admitted to the facility with orders for enteral tube feeding via gastrostomy tube received a comprehensive nutritional assessment to ensure the type and amount of tube feeding formula and free water needs are appropriate for those residents. These failures affect two of two residents (R1, R5) reviewed for gastrostomy tube feeding on the sample of five. Findings include: 1. R1's Electronic Medical Record does not document the facility completed a comprehensive nutritional assessment for R1's nutritional requirements/needs for R1's enteral tube feeding and free water flush/administration while R1 was a resident at the facility. R1's Dietary Admission/Quarterly Evaluation dated 4/26/23 is incomplete. On 5/18/23 at 3:25pm, V2, Director of Nursing (DON) stated V13, Registered Dietician (RD) comes monthly for one or two days. V2 stated V13 was here last month, always at the end of the month. V2 stated V14, Dietary Manager (DM) reaches out to the V13, is my (V2's) understanding. V2 stated there is a form to fill out and sent to V14 who gives the information to V13. V2 stated V2 was unsure if that was completed and would check with V14 but did not provide documentation of the form for R1. V2 stated residents admitting to the facility who require gastrostomy tube feeding should be assessed by V13, RD within 24 - 48 hours of admission to the facility. V2 stated, I (V2) do not recall (V13) being notified for R1. 2. R5's Admission/Readmission Nursing Evaluation dated 4/29/23 documents R5 has a gastrostomy tube to R5's abdomen. This evaluation documents R5 requires enteral feedings and that R5's enteral feeding formula as Jevity 1.5. R5's Electronic Medical Records do not document a comprehensive nutritional assessment/assessment for R5's enteral feeding/free water flushing needs. On 5/18/23 at 3:25pm, V2, Director of Nursing stated V2 didn't think V13, Registered Dietician (RD) had seen/completed an assessment for R5 and R5's enteral tube feeding requirements and free water flushes yet. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Enteral Feedings policy dated February 2008 documents the facility is to provide commercially prepared product for enteral feedings when it has been determined oral feedings are not sufficient to meet physical requirements and enteral nutrition support is deemed appropriate. This policy documents the Dietician will monitor all diet orders for tube feedings and will recommend as appropriate, changes in product according to resident need. Tube feeding nutritional infromation when ordered continuous will be calculated by the RD on a 23 hour basis to allow for non-administration time required for daily cares. The fluid intake for the resident receiving tube feeding should be equivalent to the fluid needs as assessed by the Dietician. Fluid needs may not be met by product alone in which case water flus ordered my be recommended to meet the needs of the resident. A record of daily intake of the tube feeding and the flushes for the resident will be kept by the nursing department. A physician's order will be obtained for all infusion orders prior to initiation of feeding. Physician order for pre-medication and formula administration flushes will be sought.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35510 Based on interview and record review, the facility failed to ensure residents admitted to the facility with orders for enteral tube feeding via gastrostomy tube received orders specifying formula type and amount of feeding and free water flushes to be adminsitered. The facility failed to ensure residents were monitored for intake of enteral feeding formula and free water flushes. These failures affect two of two residents (R1, R5) reviewed for gastrostomy tube feeding on the sample of five. Findings include: 1. R1's Electronic Medical Record does not document the facility completed a comprehensive assessment for R1's nutritional requirements/needs for R1's enteral tube feeding and free water flush/administration while R1 was a resident at the facility. R1's Dietary Admission/Quarterly Evaluation dated 4/26/23 is incomplete. R1's electronic Clinical Physician Orders dated 5/18/23 document R1's orders including to flush R1's gastrostomy (g-tube) tube with 30mL (milliliters) of water before and after medications. These orders document R1's diet as NPO (nothing by mouth) and an order dated 4/26/23 for enteral feeding five times daily. These orders do not document orders for free water flush/administration. R1's Medication Administration Record (MAR) dated April 2023 documents R1 is to receive enteral tube feeding of Jevity 1.5 at 70mL per hour via g-tube with 600 (no unit of measurement documented) free water flush daily. There is no documentation of how many hours the Jevity feeding was to run/be administered, or total amount of Jevity that R1 was to receive or R1 actually received daily. There is no documentation for total amount of R1's free water flushes R1 received. R1's hospital medical records dated 4/11/23 document R1 was sent to the local emergency room for g-tube replacement. These hospital records document R1 is critically ill. R1's blood was drawn on 4/11/23 at 2:45pm with results as follows: Blood Urea Nitrogen (BUN) level 61 (Reference Range 8-26mg (milligrams)/dL (deciliter) Creatinine 1.76 (Reference Range 0.70-1.30mg/dL) and Sodium 159 Critical High (Reference Range 136-145). R1's laboratory report dated 4/11/23 at 5:25pm with results as follows: Blood Urea Nitrogen (BUN) level 62 (Reference Range 8-26mg (milligrams)/dL (deciliter) Creatinine 1.75 (Reference Range 0.70-1.30mg/dL) and Sodium 161 Critical High (Reference Range 136-145). R1's hospital medical records document R1 was transferred to an advanced level of care on 4/11/23. R1's hospital medical records document laboratory results dated [DATE] at 5:07am of BUN 17, Creatinine 0. 75 and Sodium 140. R1's MAR dated May 2023 documents, Enteral Feed Order, five times a day for nutritional supplement bolus 290mL. This MAR does not identify type of tube feeding formula R1 was to receive. There is no documentation of how much free water R1 was to receive nor that R1 received free water per g-tube, only 30mL water flush before and after medication administration. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's hospital emergency room physician notes dated 5/3/23 at 8:45pm document R1 looks dehydrated. This note documents R1's [NAME] Blood Cells and Sodium levels are elevated and R1's urine is positive for infection. This note documents R1's admitting diagnoses including Hypernatremia and Urinary Tract Infection. R1's Hospital Nursing Notes dated 5/3/23 9:55pm document R1's skin turgor poor. R1's Hospital report dated 5/4/23 documents R1's medical history including Type 2 Diabetes Mellitus, Chronic Combined Systolic and Diastolic Heart Failure, 3rd & 4th degree burns of multiple sites, Percutaneous Endoscopic Gastrostomy, Chronic Anemia and Surgical Skin Grafting. This report documents R1 presented to the emergency room by emergency medical services from the facility with complaint of weakness with V12, R1's family stating R1 had increased weakness for several days and R1 was having difficulty sitting upright in bed and using his arms. This report documents R1 receives tube feeding boluses five times daily, but that V12 is unsure if R1 has been receiving supplemental water flushes. This report documents R1 had Hypernatremia with a sodium level of 153 (no unit of measurement identified). This report documents R1's sodium level results were 150 (no unit of measurement identified) this morning after initiation of IV fluids and resuming tube feedings. This report documents to start free water flushes. On 5/18/23 at 3:25pm, V2, Director of Nursing (DON) stated V13, Registered Dietician (RD) comes monthly for one or two days. V2 stated V13 was here last month, always at the end of the month. V2 stated V14, Dietary Manager (DM) reaches out to the V13, is my (V2's) understanding. V2 stated there is a form to fill out and sent to V14 who gives the information to V13. V2 stated V2 was unsure if that was completed and would check with V14 but did not provide documentation of the form for R1. V2 stated residents admitting to the facility who require gastrostomy tube feeding should be assessed by V13, RD within 24 - 48 hours of admission to the facility. V2 stated, I (V2) do not recall (V13) being notified for R1. V2 stated it is the responsibility of the nurse caring for the resident who should be following up to make sure tube feeding orders are followed up on and accurate. V2 stated the residents medical records should document the total amount of tube feeding and free water administration each resident who receives enteral feeding and should be documented each shift. V2 stated V2 was unable to find documentation for R1's enteral tube feeding and free water administration amounts. 2. R5's Admission/Readmission Nursing Evaluation dated 4/29/23 documents R5 has a gastrostomy tube to R5's abdomen. This evaluation documents R5 requires enteral feedings and that R5's enteral feeding formula is to Jevity 1.5. R5's Hydration Risk Screener assessment dated [DATE] documents hydration management planning is indicated with interventions to be implemented for hydration management including to refer R5 to V13, Registered Dietician for review/recommendations and for tube feeding review. R5's Electronic Medical Records do not document a nutritional assessment/assessment for R5's enteral feeding/free water flushing needs. R5's Clinical Physicians Orders dated 5/18/23 at 6:19pm document R5's orders including Enteral Feed one time a day, but the order does not identify what tube feeding formula R5 is to receive. There is no documentation of free water flush orders for R5 or that R5 is receiving any free water flushes. (continued on next page)

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	145389	A. Building B. Wing	05/18/2023

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Watseka Rehab & Hlth Care Ctr	715 East Raymond Road Watseka, IL 60970

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's Medication Administration Record (MAR) dated May 2023 documents R5 is to receive enteral feeding one time a day for Dysphagia 70cc (cubic centimeters) per hour. This MAR does not document what tube feeding formula R5 is receiving. There is no documentation R5 is receiving free water flushes. On 5/18/23 at 3:25pm, V2, Director of Nursing stated V2 didn't think V13, Registered Dietician (RD) had seen/completed an assessment for R5 and R5's enteral tube feeding requirements and free water flushes yet. V2 stated V2 thinks R5 is to have Jevity 1.5 enteral feeding formula. V2 stated, usually tube feeding administrations run over 22 hours a day with 2 hours where the tube feeding pump is shut off/not administering the tube feeding formula. V2 stated V2 is unaware of the amount of tube feeding formula R5 is to receive in a 24 hour period and that all that information should all be documented on each residents Medication Administration Record and Physicians Orders. V2 stated each resident receiving enteral tube feedings, should have an order specifying what tube feeding formula and total amount to be infused over a certain/prescribed time span. V2 stated free water flushes should be documented on the MAR too with documentation of actual amount administered. V2 stated V2 is unable to find documentation for R5's enteral tube feeding and free water administration amounts/totals. The facility's Enteral Feedings policy dated February 2008 documents the facility is to provide commercially prepared product for enteral feedings when it has been determined oral feedings are not sufficient to meet physical requirements and enteral nutrition support is deemed appropriate. The fluid intake for the resident receiving tube feeding should be equivalent to the fluid needs as assessed by the Dietician. Fluid needs may not be met by product alone in which case water flus ordered my be recommended to meet the needs of the resident. A record of daily intake of the tube feeding and the flushes for the resident will be kept by the nursing department. A physician's order will be obtained for all infusion orders prior to initiation of feeding. Physician order for pre-medication and formula administration flushes will be sought. The facility's Enteral Feeding Closed System Ready to Hang Product policy dated February 2008 documents the facility is to document information related to feeding on the flow record and/or Treatment Administration (TAR) or Medication Administration Records (MAR). The facility's Enteral Tube Feeding Bolus Procedure policy dated April 2007 documents the facility is to provide nutrition via gastrostomy tubes when ordered by a physician. This policy documents after the tube feeding formula is administered, the facility is to flush the tube with 30cc of water or per physician order. This policy documents the facility is to document information related to feeding on the flow record and/or TAR/MAR.

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F 0695 Level of Harm - Actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 35510 Based on interview and record review, the facility failed to ensure a resident received proper tracheostomy care to prevent the tracheostomy from becoming occluded and assist in respiratory infection prevention. This failure affects one of two residents (R1) reviewed for tracheostomy care on the sample of five. These failures resulted in R1 becoming hypoxic and requiring hospitalization . Findings include: R1's Hospital records document an Assessment and Plan dated 3/30/23 at 2:08pm, including R1 has a history of Heart Failure, Chronic Hypoxemic Respiratory Failure status post Tracheostomy in March 2020. This plan documents R1 requires continuous trach collar at 26%, titrate supplemental Oxygen to maintain Oxygen Saturations of 90-96%. R1's Progress Notes dated as follows document: 4/7/23 at 2:00pm document R1 admitted to the facility and that R1 has a tracheostomy (trach.) 4/10/23 at 11:15am - Noted to have frequent cough with return of thick mucous. Holds on to hard suction catheter device and R1 will self suction. R1's Hospital records document on 4/11/23 at 2:00pm, R1 just left a LTAC (Long Term Acute Care facility) after a year long admission. These records document R1 admitted to the facility 4 days ago (4/7/23) and has now been in the Emergency Department twice. This note documents R1 is hypoxic on trach collar to 89%-91% with copious trach secretions. R1's emergency room physician note dated 4/11/23 at 8:00pm documents R1 presents with excessive trach secretions, cough. This note documents R1's labs are concerning with an elevated [NAME] Blood Cell count, and a Chest X-ray consistent with Pneumonia. This note also documents R1 required 1 hour worth of suctioning and trach care upon arrival to the hospital and that R1 is critically ill. The Hospitalist Admit Note dated 4/12/23 documents R1 admitted to the hospital on 4/11/23 with a chief complaint of Respiratory Failure. This note documents R1 arrived to the emergency room hypoxic on 8L (liters). Tracheostomy noted to produce copious sputum. The chest X-ray was concerning for left basilar pneumonia. R1 reported R1's symptoms began about 8 days ago, last Monday. This note documents R1 has a tracheostomy XLT (Extra Length Tracheostomy) tube, 6.0mm (millimeter) ID (Inner diameter)/11.0mm OD (Outer Diameter) tracheostomy in place. R1 is coughing, producing purulent-appearing yellow mucus through tracheostomy. R1's lungs had mild diffuse adventitious lung sounds. This note documents R1 has Bilateral Pneumonia (likely bacterial) in a patient with significant risk for Aspiration Pneumonia, Acute on Chronic Hypoxic Respiratory Failure (increased work of breathing and Oxygen Saturation under 90% prior to arrival to the hospital) secondary to Pneumonia and Lactic Acidosis secondary to above. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	R1's Hospital Medical Records document a Pulmonary Tracheostomy Tube change procedure note dated 4/24/23 documents R1 had a size #6 XLT cuffed tracheostomy tube in place with the cuff deflated. R1 had a size #6 Cuffless XLT Tracheostomy tube placed on this date. These hospital records document problems with tracheostomy care and suctioning at the facility. These notes document to consider standing tracheostomy suction and care order at the time of discharge. R1's Treatment Administration Record (TAR) dated April 2023 documents R1 is to receive: Oxygen - Oxygen at 8 L (liters) per trach collar every shift with a Start Date of 04/07/2023 6:00pm. There is no documentation of humidification administration with the Oxygen. Trach: Site care - Remove dressing from under flange, cleanse outer cannula and skin daily with Normal Saline (NS) and gauze. Cleanse under cannula with cotton applicator and replace dressing under the flange, every shift with a start date of 4/8/23 at 6:00am. There is no documentation of the care of R1's inner cannula or if the inner cannula was disposable. Trach: May Suction Tracheostomy to maintain O2 (Oxygen) saturations, when coughing or excess secretions noted as needed for secretions with a start date of 4/7/23 at 3:12pm. R1's TAR dated May 2023 documents R1 is to receive: Oxygen - Oxygen at 8 L per trach collar every shift with a Start Date of 04/07/2023 6:00pm. There is no documentation of humidification administration with the Oxygen. Trach: Site care - Remove dressing from under flange, cleanse outer cannula and skin daily with NS and gauze. Cleanse under cannula with cotton applicator and replace dressing under the flange, every shift with a start date of 4/8/23 at 6:00am. There is no documentation R1 received this trach site care on this TAR. There is no documentation of the care of the inner cannula or if the inner cannula was disposable. Trach: May Suction Tracheostomy to maintain O2 sats, when coughing or excess secretions noted as needed for secretions with a start date of 4/7/23 at 3:12pm. There is no documentation of respiratory therapy evaluation/care by the facility's respiratory company. There is no documentation of emergency equipment located at R1's bedside, including ambu bag or replacement tracheostomy tube. On 5/10/23 at 7:50am, V12, R1's Family stated V12 spent hours at the facility every day. V12 stated one unidentified nurse (per V12, unable to know most names due to no name tags) used the flexible suction catheter and attempted to place it in R1's mouth and suction down R1's throat. V12 stated R1 put R1's hands up and panicked. V12 stated V12 told the nurse R1 could not be suctioned that way and told the unidentified nurse how to suction R1 but the nurse wound not deep suction R1. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	On 5/10/23 at 1:48pm, V11, Respiratory Therapy Supervisor stated V11 received report from V10, Respiratory Therapist on R1. V11 stated R1's tracheostomy was completely occluded upon arrival to the emergency room and that R1's rigged up tubing with blue cap contained hard, crusted build-up inside the tube. V11 stated due to the condition of the tracheostomy and dressing around the tracheostomy, the facility had not been providing tracheostomy care for R1 as R1 required. V11 stated R1's thick copious secretions were signs R1 was not receiving humidification for R1's tracheostomy and should have been. V11 stated R1's tracheostomy dressing was so stuck to R1's skin that it had to be soaked multiple times to be able to remove it from around R1's tracheostomy and R1's skin under the tracheostomy dressing was red/irritated. V11 stated R1's tracheostomy showed signs it was severely neglected by the facility. The facility's Tracheostomy Care policy dated 3/29/2019 documents tracheostomy care should be performed once per shift or as often as required to maintain patency of airway and minimize risk of infection. This policy documents to remove old tracheostomy dressing, and to change a disposable inner cannula daily. This policy also documents to replace the drain sponge behind the tracheostomy plate if being used.