

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6005888</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/09/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MATTOON REHAB &amp; HCC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2121 SOUTH NINTH MATTOON, IL 61938</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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S 000	Initial Comments  IRI 11/10/2016/IL90293	S 000		
S9999	Final Observations  Statement of Licensure Violations:  300.1210b) 300.1210d)6 300.3240a)  Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident These Regulations are not met as evidenced by: Based on record review and interview, the facility	S9999		

**Attachment A**  
**Statement of Licensure Violations**

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE <b>12/22/16</b>
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S9999	<p>Continued From page 1</p> <p>failed to follow identified fall interventions for one (R1) resident. This failure resulted in R1 falling two times and sustaining a laceration on the first fall and a fractured clavicle on the second fall. In addition, facility staff failed to transfer one resident (R3) safely from a chair to a standing position. R1 and R3 are two of three residents reviewed for falls in the sample of three.</p> <p>Findings include:</p> <p>1). a.) The Physician Order Sheet for R1 dated December 2016 documents the following diagnoses: Parkinson's Disease, Difficulty in Walking, Muscle Weakness, Dementia, Anxiety and Fractures of the Nasal Bones, Olecranon (elbow) and Clavicle.</p> <p>The Minimum Data Set (MDS) for R1 dated 7/1/16 and 9/29/16 document R1 as being severely cognitively impaired. The same MDS's document R1 needing physical assistance of one and two respectively, with toileting and transfers.</p> <p>R1's Fall Risk Assessments dated July 2016 through November 2016 document R1 at High Risk for Falls.</p> <p>R1's Plan of Care dated November 2016 documents the following interventions for related falls: On 3/20/16, an intervention was added to the Plan of Care for R1 to be placed at the Nurse's Station or in an Activity when up in wheelchair and or at meals in order to prevent falls. On 8/31/16, the Plan of Care was updated to include the fall intervention directing staff not to leave R1's wheelchair in R1's room when R1 is in bed.</p> <p>A facility report titled "Fall Details Report" dated</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>8/5/16 documents the following: On 8/5/16 at 4:45 am, R1 was found on the floor in R1's room. R1 was transferred to the emergency room due to a 3.5 to 4.0 centimeter (cm) laceration above the left eye. The facility investigation report documents that R1 had been left alone at the nurses station in R1's wheelchair. R1 then propelled the wheelchair per self, back to R1's room and attempted to self-transfer back to bed. The report states "staff failed to follow (R1's) plan of care of not being left alone while up in his wheelchair." The report is signed by E2, Director of Nursing.</p> <p>An Emergency Room Note dated 8/5/16 at 6:15 am documents the following: (R1) is seen in the emergency room "with head injury after fall from wheelchair. There is a 5.0 cm laceration to the left eyebrow, 1.0 cm superficial laceration to the inferior orbital rim.....(laceration of left eyebrow) - Complex wound closure requiring subcutaneous sutures, (laceration of left infraorbital rim) - Dermabond."</p> <p>On 12/09/16 at 10:0 am, E2 stated the fall of 8/5/16 was due to facility staff not following R1's Plan of Care and R1 should not have been left alone at nurses station, allowing R1 to return to R1's room in the wheelchair alone.</p> <p>On 12/09/16 at 1:40 pm Z1, Primary Care Physician for R1 stated staff should not have allowed R1 to return to R1's room in the wheelchair alone. R1 is known for trying to self transfer and has fallen before. Z1 acknowledged the fall from the wheelchair on 8/5/16 caused R1 to sustain facial lacerations requiring treatment at the emergency room. Z1 stated "staff need to follow (R1's) Plan of Care, interventions are in place for a reason."</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>b.) A facility report titled "Fall Details Report" dated 10/16/16 documents the following: On 10/16/16 at 7:00 am, R1 was heard yelling for help. "It appears that (R1) crawled off of mat and pulled self up with wheelchair in corner of room and then fell.....(R1) has mild (complaints of) left shoulder and left hip pain." Z1 ordered an x-ray to the left shoulder of R1.</p> <p>A Radiology Report on R1, dated 10/16/16 at 2:08 pm documents the following: Reason for x-ray - "pain status post fall." Results - "here is a fracture involving the distal clavicle with minimal displacement."</p> <p>On 12/9/16 at 10:10am, E2 acknowledged that R1's Plan of Care included the intervention of not leaving R1's wheelchair in R1's room. The intervention was implemented from an identified root cause on a fall dated 8/29/16 when R1 had fallen while trying to self transfer and had hit R1's head. E2 acknowledged that staff had not followed the Plan of Care and had left R1's wheelchair in R1's room on 10/16/16, allowing R1 accessibility to the wheelchair to self transfer, causing R1 to fall and fracture R1's clavicle.</p> <p>On 12/09/16 at 1:40 pm Z1 stated that the fall on 10/16/16 while R1 was trying to self transfer to the wheelchair did result in a fall with a fractured clavicle. Z1 stated that R1's wheelchair is not to be left in R1's room due to R1's previous attempts at self transfers. Z1 stated "Staff need to follow the Plan of Care on R1."</p> <p>2.) The Physician Order Sheet (POS) dated December 2016 for R3 documents the following diagnoses: Aftercare for Fracture of Right Tibia, Parkinson's Disease, Difficulty in Walking, Muscle</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>Weakness, Anxiety and History of Falls. Included on the POS is an order dated 9/27/16 for R3 to be non-weight bearing on the right casted lower extremity.</p> <p>R3's Minimum Data Set (MDS) dated 10/4/16 documents that R3 requires extensive assistance with two staff for transfers and toileting.</p> <p>R3's Plan of Care dated September 2016 documents that R3 needs extensive assist with transfers, toileting, walking, and bathing.</p> <p>R3's Fall Risk Assessment dated 9/27/16 documents R3 as being at high risk for falls.</p> <p>A facility report titled "fall Details Report" dated 10/7/16 documents R3 being lowered to the floor on 10/7/16 at 7:25 pm by E6, Certified Nursing Assistant (CNA). The report documents that E6 attempted to transfer R3 to a wheelchair from a recliner. When E6 stood R3 up, R3's good foot (uncasted leg) started to slide and E6 had to lower R3 to the floor. R3 had no shoes on but only slipper socks at the time. The report documents that "Therapy is to in-service CNA on proper transfer."</p> <p>On 12/9/16 at 10:10 am, E2, Director of Nursing stated that CNA, E6 transferred R3 improperly. E2 acknowledged that E6 was in front of R3's walker and E6 was the only CNA present for the transfer.</p> <p>(B)</p>	S9999		