Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005888	A. BUILDING: ______ B. WING ______	C 06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MATTOON REHAB & HCC	2121 SOUTH NINTH MATTOON, IL 61938

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S 000	Initial Comments	S 000		
	Complaint Investigation #1763749/IL94945			
S9999	Final Observations	S9999		

Statement of Licensure Violations:

300.610 a)
300.690 a) b) c)
300.1210 c)
300.1210 d) 6)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,

Attachment A
Statement of Licensure Violations

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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

Based on observation, interview and record review the facility failed to follow manufacturer's instructions for air mattress overlay application and failed to ensure fall interventions were in place for three of four residents (R1, R3 and R4) reviewed for falls in the sample of five. These failures resulted in R1 falling and sustaining a hematoma with active bleeding, blood transfusions, and R3 falling and sustaining facial lacerations which required seven sutures.

Findings include:

1. The Physician's Order Sheet (POS) dated 6/28/17 documents R1 has diagnoses of Right Sided Hemiplegia and Hemiparesis, Muscle Weakness, Speech and Language Deficits Following Cerebral Infarctions and a History of Falling. The Minimum Data Set (MDS) dated 5/26/17 documents R1 is severely cognitively impaired and requires extensive to total assistance from staff for transfers, bed mobility and activities of daily living. R1's Care Plan updated 6/15/17 documents an intervention of "(Z6 Family Member) states that (R1) currently is not able to use the call light. (R1) will be on 15 minute visuals to assess (R1's) needs" with an initiated dated of 2/25/17.

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S9999	Continued From page 2 The 15 minute check off sheet documents R1 was visually observed on 6/15/17 at 2:03 am and then not observed again until 2:45 am when (R1) was found on the floor. E20's (Registered Nurse) Nurses Note dated 6/15/17 states "At 2:45 am this nurse went to answer the call light and resident (R1) was laying on the floor beside the bed with (R1's) head on the floor and feet tangled in the sheets on the bed. Mostly laying on (R1's) left side and back position. Assisted resident off the floor using the (mechanical lift). Neuro assessment initiated. V.S. (vital signs) and skin assessment. A 1.0 cm (centimeter) x 2.0 cm check shaped abrasion noted to left upper mid back shoulder area. Area was cleansed, TAO (triple antibiotic ointment) and protective cover applied. Area noted to be swelling, ice pack applied. PRN (as needed) pain medication given. Z1 Physician notified, orders received X-ray the left shoulder and left rib areas. Phone call to on-call nurse E14 Registered Nurse, informed of fall. Intervention was to remove the (specialty) air mattress overlay to the bed." E3's (Registered Nurse) Nurses Note dated 6/15/17 at 6:28 am states "(R1) is currently experiencing severe back pain s/p (status post) fall from bed" The note also states "RN to RN report revealed patient has fallen, MD (Medical Doctor) notified n.o. (new order) for back x ray, rib x ray to be done in house. CNA (Certified Nurses Aide) to CNA report occurred and noc (night) and day shift CNAs summoned the RN to the resident's bedside. Resident is diaphoretic. Blood glucose of 222. Resident reports extreme pain." E3's Nurses Note dated 6/15/17 at 6:35 am	S9999		

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states "(R1) is extremely diaphoretic, blood glucose of 222. Resident reports back pain, thoracic spine appears edematous and is painful. Send to ED (Emergency Department) per Z7 (physician) on call for Z1 Physician."

The Hospital Preliminary Report dated 6/15/17 documents "(R1) is found to have a large soft tissue hematoma with some active contrast extravasation (leakage) that is consistent with active bleeding posterior to the T7 (thoracic vertebra) and T8 intercostal space on the left side. There is no noted fracture, however there is a significant hematoma noted. The Report documents an assessment of "Anemia likely secondary to hematoma" and states that R1 was admitted to the hospital for pain control, bleeding control and a surgical consult.

The Hospital Progress Note dated 6/16/17 documents "(R1) has had s\s (signs and symptoms) of pain this shift treated with Dialudid (strong narcotic pain medicine)."

The Hospital Discharge Summary dated 6/19/17 documents "(R1) was admitted after a fall at the NH (nursing home). (R1) was noted to have a traumatic hematoma to (R1's) thoracic region. Surgery was consulted and a binder was placed. On 6/16/17 (R1) had 2U PRBC (units packed red blood cells) transfused for a Hgb (hemoglobin) (blood count) less than 8 (normal 11.3-15.2) and on 6/18/17 (R1) was transfused 2U PRBC. (R1's) Hgb improved from 7.7 up to 11.3 after the transfusion and then increased again up to 11.5 the morning of discharge. The hematoma improved and (R1) was discharged back to the skilled nursing facility to continue recovery after (R1's) (prior) stroke."

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The Facility Occurrence Review dated 6/15/17 documents E20's Nurses Note of "what happened" when R1 fell on 6/15/17 as "(specialty) air mattress overlay on bed was slid over the edge of the bed" and "(R1) stated that (R1) was trying to turn over." The Fall Details Report dated 6/15/17 documents that R1 was last observed prior to the fall at 1:45 AM. The Follow Up Report dated 6/22/17 documents a conclusion of "The (specialty) air mattress overlay had slid off the edge of the bed when (R1) tried to turn over causing (R1) to slide off the side off the bed. The (specialty) air mattress overlay has been removed."

On 6/28/17 at 4:20 am E20, RN, stated that on 6/15/17 E20 answered the call light in R1's room and found R1 half in the bed and half out of the bed. E20 stated the air mattress topper slid off the bed. E20 stated "There is no strap to keep the air mattress topper on the bed, there was nothing to keep the topper on." E20 stated E20 did not know R1 was on 15 minute visual checks.

On 6/28/17 at 8:55 am E17, Certified Nurses Aide (CNA), stated E17 was R1's CNA when R1 fell on 6/15/17. E17 stated E17 did not know R1 was on 15 minute checks.

On 6/28/17 at 9:25 am Z5, (specialty) Air Mattress Overlay System Representative, stated that the system is delivered to facilities with an instruction manual and straps that should be used to attach the overlay to the top of the mattress corners.

On 6/28/17 at 10:40 am E1, Administrator, and E2, Director of Nurses, stated they were unaware of straps that secure the air mattress overlay to the mattress.

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The undated (Specialty) Non-Powered Mattress Overlays and Accessories Operation Manual states "Attachment of Overlay Straps Note Four Overlay Straps are included to aid in securing the (specialty air mattress overlay) to the bed mattress. 1. Attach one strap to each corner of the mattress overlay. 2. Stretch the straps around the corners of the bed mattress to secure the mattress overlay to the bed mattress."

On 6/28/17 at 10:53 am Z4, Hospital Attending Physician, stated (R1) suffered the hematoma when (R1) rolled out of bed. Z4 stated the hematoma continued to bleed and that was the reason (R1) was admitted the the hospital. Z4 stated (R1) has some chronic anemia but the (acute) anemia was probably realted to the hematoma. Z4 stated (R1) received four units of blood while (R1) was hospitalized.

2. R3's Physician Order Sheet (POS) dated June 2017 documents the following medical diagnoses: Dementia with Behavioral Disturbance Alzheimer's Type, Anxiety, Hypertension, Muscle Weakness, Difficulty Walking and Polyosteoarthritis. The same POS documents and an antipsychotic medication order of Risperdal 0.5 milligram (mg) each morning and 1 mg each evening.

R3's MDS dated 3/23/17 documents R3 received a BIMS score of 6 out of a possible 15, rating R3 as severely cognitively impaired and is totally dependent on two physical staff assistance for bed mobility and transfer.

R3's current Care Plan, dated 6/15/17 includes the following, "Focus (Problem): (R3) is at risk for falls, (due to) poor comprehension, psychoactive

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drugs and a history of falls." The same Care Plan documents a "Regular mattress with air overlay placed by Hospice, resolved 4/30/17 (post fall 4/30/17)."

The "(Local) Home Medical Equipment Checklist" dated 4/19/17, signed by the Z3, Company Representative, and E3, Registered Nurse, documents the (Local) Hospice, Alternating Pressure Mattress and Pad" were delivered and set up on R3's bed 4/19/17.

On 6/28/17 at 12:10 pm, E3 stated, "I signed that we (the facility) received this Hospice equipment. The delivery person (Z3) applied them (Alternating Pressure Mattress and Pad) to (R3's) bed that day, 4/19/17."

R3's "Fall Detail Report" dated 4/30/17 at 00:00 am (midnight), documents E8, Certified Nursing Assistant (CNA), witness interview statement that E8 observed R3 on the floor. "(R3) was between the bed (and), trash can, by the wall, with a pool of blood underneath (R3). (R3) previously had a bolstered (raised edge) mattress. The night of the occurrence (Fall 4/30/17), (R3) had a regular mattress with an air overlay that was provided by Hospice. The mattress was springy. (R3) did not have a grab bar or side rail in place. (R3) used to have one about a month ago"

R3's "Fall Detail Report" dated 4/30/17 at 00:00 am (midnight) documents a second witness interview statement given by E21, CNA, as follows: E21 walked in the room, "(R3) was lying face down on the floor with her (R3) head resting on the trash can." E21 also stated "When they (E8 and E21) checked out the mattress, it was springy, and anyone would have rolled out of bed."

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R3's "Fall Detail Report" dated 4/30/17 at 00:00 am, documents the following fall investigation conclusion, written by E2, Director of Nursing: "Facility has determined that the root cause of the fall was a regular, springy mattress in combination with the air overlay causing (R3) to roll out of bed. (The) mattress was replaced with the original bolstered mattress while (R3) was seeking treatment at ER (Emergency Room) for injuries." The same report documents "Root Cause, Human Error."

On 6/27/17 at 2:25 pm, E2, DON stated the following: "I did not initiate the regular mattress and waffle type air mattress topper. Usually I call them (Hospice) with the need for the equipment. That was not the case for (R3's). Hospice (unidentified person) implemented the mattress and air topper on their own. It was determined that it was Hospice human error that caused (R3) to roll out of bed (4/30/17). (R3) had a bolster / concave mattress which is what (R3) needed prior to (Hospice application of the regular mattress and air topper). We re - implemented the concave / bolster mattress, which never should have been removed, while (R3) was in ER (post fall 4/30/17) which resulted in seven stitches."

The (Local) hospital "Emergency Documentation" report dated 4/30/17 documents the following: "Chief Complaint, fall out of bed, struck head, laceration to nose, left check and left ear." The same report documents, "(R3) presents via ambulance from skilled nursing facility. The patient (R3) rolled out of bed and collapsed a garbage can that was adjacent to the bed." "Emergency Room Course, The patients (R3) wounds were cleansed with saline, a total of four

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milliliters of two percent lidocaine without epinephrine was infiltrated. Two times 5 - 0 nylon sutures were used to close the nasal laceration. Three times 5 - 0 nylon suture were used to close the superior pinna (top of ear) laceration. Two times 5 - 0 nylon sutures were used to close the posterior (back) left ear laceration (total of seven sutures)."

On 6/28/17 at 10:47 am , Z1, Physician stated the following: "(R3's) fall from bed, and subsequently hitting the garbage can caused the facial lacerations that resulted in the stitches to her (R3) face (4/30/7)."

3. The POS dated 6/28/17 documents R4 has diagnoses of Epilepsy and Dementia with Behavioral Disturbance. The MDS dated 4/11/17 documents R4 is severely cognitively impaired and requires extensive to total assistance with activities of daily living.

On 6/28/17 at 6:25 AM E12, CNA, and E6, CNA, repositioned R4 in R4's bed. R4 was laying in bed on a specialty air mattress over lay. At that time the air mattress overlay was not secured to the mattress.

On 6/28/17 at 9:30 am R4's (specialty) air mattress overlay was observed with E10, CNA. E10 lifted the air mattress overlay off of R4's mattress and stated there is nothing on R4's air mattress to keep it from sliding.

The undated (Specialty) Non-Powered Mattress Overlays and Accessories Operation Manual states "Attachment of Overlay Straps Note Four Overlay Straps are included to aid in securing the (specialty air mattress overlay) to the bed mattress. 1. Attach one strap to each corner of

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the mattress overlay. 2. Stretch the straps around the corners of the bed mattress to secure the mattress overlay to the bed mattress."

The facility "Fall Prevention Policy (Safety Assessment, Fall Prevention and Education / S.A.F.E.)" dated February 2014 documents the following: "The S.A.F.E. program promotes Safety Assessments, Fall Prevention, and Education of both staff and residents. "All Occurrence Reports are reviewed at the daily QA (Quality Assurance) meeting to ensure that intervention was immediately implemented, added to the plan of care and that the current intervention is appropriate."

Section 300.690 Incidents and Accidents

a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.

b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.

c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local

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law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

(Source: Amended at 37 Ill. Reg. 2298, effective February 4, 2013)

This requirement is not met as evidenced by:

Based on interview and record review the facility failed to notify the Illinois Department of Public Health of a fall that resulted in a resident sustaining a hematoma with active bleeding, and requiring blood transfusions for one of four residents (R1) reviewed for falls in the sample of five.

Findings include:

E20's, Registered Nurse, Nurse Note dated 6/15/17 states "At 2:45 am this nurse went to answer the call light and resident (R1) was laying on the floor beside the bed with (R1's) head on the floor and feet tangled in the sheets on the bed. Mostly laying on (R1's) left side and back position. Assisted resident off the floor using the (mechanical lift). Neuro assessment initiated. V.S. (vital signs) and skin assessment. A 1.0 cm (centimeter) x 2.0 cm check shaped abrasion noted to left upper mid back shoulder area. Area

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was cleansed, TAO (triple antibiotic ointment) and protective cover applied. Area noted to be swelling, ice pack applied. PRN (as needed) pain medication given. Z1 Physician notified, orders received X-ray the left shoulder and left rib areas."

E3's, Registered Nurse, Nurses Note dated 6/15/17 at 6:28 am states "(R1) is currently experiencing severe back pain s/p (status post) fall from bed" The note also states "RN to RN report revealed patient has fallen, MD (Medical Doctor) notified n.o. (new order) for back x ray, rib x ray to be done in house. CNA (Certified Nurses Aide) to CNA report occurred and noc (night) and day shift CNAs summoned the RN to the resident's bedside. Resident is diaphoretic. Blood glucose of 222. Resident reports extreme pain."

E3's Nurses Note dated 6/15/17 at 6:35 am states "(R1) is extremely diaphoretic, blood glucose of 222. Resident reports back pain, thoracic spine appears edematous and is pain. send to ED (Emergency Department) per Z7 (physician) on call for Z1 (Physician)."

The Hospital Preliminary Report dated 6/15/17 documents "(R1) presented to the hospital today after a fall at the nursing home. Patient has a recent history of an intracrainial hemorrhage." The Report also states "(R1) is found to have a large soft tissue hematoma with some active contrast extravasation (leakage) that is consistent with active bleeding posterior to the T7 (thoracic vertebra) and T8 intercostal space on the left side. There is no noted fracture, however there is a significant hematoma noted. The Report documents an assessment of "Anemia likely secondary to hematoma" and states that R1 was

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admitted to the hospital for pain control, bleeding control and a surgical consult.

The Hospital Progress Note dated 6/16/17 documents "(R1) has had s\s (signs and symptoms) of pain this shift treated with Dialudid (strong narcotic pain medicine)."

The Hospital Discharge Summary dated 6/19/17 documents "(R1) was admitted after a fall at the NH (nursing home). (R1) was noted to have a traumatic hematoma to (R1's) thoracic region. Surgery was consulted and a binder was placed. On 6/16/17 (R1) had 2U PRBC (units packed red blood cells) transfused for a Hgb (hemoglobin) (blood count) less than 8 (normal 11.3-15.2) and on 6/18/17 (R1) was transfused 2U PRBC. (R1's) Hgb improved from 7.7 up to 11.3 after the transfusion and then increased again up to 11.5 the morning of discharge. The hematoma improved and (R1) was discharged back to the skilled nursing facility to continue recovery after (R1's) (prior) stroke."

On 6/27/17 at 2:05 PM E2, Director of Nurses, stated R1's 6/15/17 fall was not reported to the Illinois Department of Public Health (IDPH).

On 6/28/17 at 10:40 am E1, Administrator, stated staff should report falls with significant injury to IDPH. E1 stated the facility does not have a policy to guide staff on reporting falls with injury to IDPH.

(B)