PRINTED: 10/19/2022

FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ C IL6005888 09/01/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2121 SOUTH NINTH MATTOON REHAB & HCC MATTOON, IL 61938 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S 000 **Initial Comments** S 000 Complaint 2266937/IL150703 S9999 Final Observations S9999 Statement of Licensure Violations: 300.690b) 300.690c) Section 300.690 Incidents and Accidents 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 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. This requirement is not met as evidenced by: Attachment A Statement of Licensure Violations Based on record review and interview, the facility

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE ...

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:  B. WING		(X3) DATE SURVEY COMPLETED		
	IL6005888					C 09/01/2022	
NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY, STATE, ZIP CODE		1 08/0	1 09/01/2022	
MATTOC	NREHAB & HCC	2121 SOU	TH NINTH N, IL 61938				
(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	
S9999	Continued From page 1		S9999		-		
	within the required :	sident incident with an injury 24-hour time frame. This esident (R1) out of three the sample of 10.			Э		
	Findings include:						
	rectangular dressing	am, R1 was lying in bed with a g approximately 12" long on which was covered by thin arent hosiery.				9,	
	my leg, it took 40 st	am, R1 stated, "I got a cut on itches to close it up. There that the nurse at the hospital	**		ν.	£	
	8/28/22 at 7:02 am avulsion is a kind of torn away from its n the right lateral leg f malleolus (ankle) to knee) and behind th leg is 9.5 inches lon gaping 1.25 inches a Emergency Departn	epartment Course dated documents, "A large avulsive ( injury in which a body part is ormal position) skin tear on rom above the lateral the fibular head (below the e calf. The wound on the right g in an arcing 'C' shape, at the widest." This nent Course documents the suture the laceration closed.		••			
	documents "(R1) is laceration on the riginaries Note dated 8 documents "Blood blateral leg, EMS (Emdispatched for transparents")	ht lateral leg." A subsequent 3/28/22 at 4:23 am egan to gush from right nergency Medical Service) port, (physician designee, b be sent to ER (Emergency		20 K			
	R1's SBAR (Situation	n, Background, Assessment,		3.			

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ C JL6005888 B. WING 09/01/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2121 SOUTH NINTH MATTOON REHAB & HCC MATTOON, IL 61938 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE **DEFICIENCY**) S9999 Continued From page 2 S9999 Recommendation) Report dated 8/28/22 at 4:15 am, confirms the time of the incident involving R1 experiencing the right leg laceration and being sent to the Emergency Room. The facility's Initial Report dated 8/29/22 at 10:22 am documents the initial incident involving R1 was reported (faxed) to the Illinois Department of Public Health Regional Office at this date and time. On 9/1/22 at 2:29 pm, V2, Director of Nursing. stated, "From the time of the incident this would be a late reporting." On 9/1/22 at 2:29 pm, V1, Administrator, stated, "We don't have a policy for reporting incidents specifically, we just follow the regulation." (C)