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 _____	08/24/2022

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 Annual Licensure and Certification Survey	S 000		
S9999	Final Observations #1 Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c)3) 300.1210d)5) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or	S9999		

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S9999	Continued From page 2 agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on observation, interview and record review, the facility failed 1) to provide interventions to prevent pressure ulcers. This failure affects one resident (R68) reviewed for pressure injuries. This failure resulted in R68 developing a full skin thickness (stage three) facility acquired pressure injury. Findings include: 1) The facility Pressure Ulcer Prevention Policy dated 3/21 documents, "A facility must evaluate resident specific risk factors and changes in the resident's condition that may impact the development and or healing of a pressure injury. The facility must implement, monitor and modify interventions to attempt to stabilize, reduce or removed underlying risk factors. Interventions for those at moderate risk include protecting heels by floating and pressure redistribution support surfaces while in the chair and bed." R68's 8/3/22 skin assessment documents R68 at moderate risk for pressure injury. R68's 8/4/22 wound physician note documents a new wound to the left posterior ankle, sized 0.5 centimeter x 1centimeter x immeasurable in depth with unstageable necrosis. R68's 8/12/22 wound physician note documents the left posterior ankle wound size as 0.3centimeter x 0.8 centimeter x unstageable necrosis.	S9999		

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S9999	Continued From page 3 R68's 8/18/22 wound physician note documents the left posterior ankle wound size as increased to 2 centimeter x 2.5 centimeter x 0.1centimeter with a deteriorated condition. On 8/22/22 at 11:00AM, R68 was sitting in her bed without any pillows or pressure reducing devices under her left ankle/leg. Later that day at 12:28PM, R68 was sitting in the dining room in a positioning chair without any pressure relieving mechanism under her left ankle/leg. R68's ankles were resting directly on the leg/foot pedals. On 8/23/22 at 12:00PM R68 was sitting in the dining room with her ankles/legs resting directly on the positioning chair without any pressure relieving mechanism under her left ankle/leg. On 8/24/22 at 8:31AM V19 Certified Nursing Assistant stated, "I remember that her left leg/ankle was red for maybe 4-5 days and then it opened and we told the nurses. She always rubbed her leg against the cast." On 8/24/22 at 8:35AM V20 Licensed Practical Nurse stated, "I think that she rested that leg on the cast and over time, the pressure caused the wound." On 8/24/22 at 10:00AM, R68 was lying in bed without any pressure relieving mechanism under her left posterior calf wound. V11 Licensed Practical Nurse (LPN) stated, "She should have her ankles floated on a pillow. I will do that." On 8/24/22 at 10:04AM V15 LPN and V11 LPN changed the dressing on R68's left posterior ankle. The wound appeared dime sized with	S9999		

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S9999	Continued From page 4 yellow slough and had a deep purple, crescent shape below the open wound. On the side of the wound that slough did not cover, tissue could be seen into the fascia (full thickness). The wound was cleansed and dressed per physician order. V11 LPN stated, "This was preventable if the legs/ankles had been propped with pressure reducing boots or pillows." On 8/24/22 at 10:05AM R68 stated, "Oh that feels better!" after V11 LPN placed a pillow under her bilateral ankles and legs. On 8/24/22 at 10:20AM, V2 Director of Nursing stated, "I have to say that it was preventable. There should have been something put between the pressure areas and the skin." Based on observation, interview and record review the facility failed 2) to assess a resident for the presence of a pressure ulcer, after being notified the resident had a complaint of coccyx pain due to pressure. This failure affects one (R9) resident reviewed for pressure ulcers. Findings include: 2 a. R9's Daily Skilled Nurse's Note dated 8/19/2022 at 9:00 pm documents: "(R9) is alert and has no memory problems. (R9) can recall all. (R9) does not have delusions, does not hallucinate, and decision making is not impaired. Signs of delirium: none. Other cognitive concerns: none." On 08/21/22 at 3:34 pm R9 reached behind her back and patted her buttocks while sitting in bed. R9 stated R9 has a facility acquired pressure ulcer on R9's coccyx. R9 stated "My (R9's) coccyx hurts from sitting on the bedside	S9999		

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S9999	Continued From page 5 commode 15 -20 minutes waiting for staff to answer the call light or just come back when they say they will." R9 also stated the following "The bandage came off yesterday (8/21/22) while sitting on the bedside commode and a CNA (unidentified, Certified Nursing Assistant) was aware, but no one has put a new one back on." On 8/21/22 at 3:45 pm V15, Licensed Practical Nurse (LPN) was notified by the surveyor that R9 complained of pain and pressure ulcer on R9's coccyx. V15, LPN stated R9 does not have a pressure ulcer and has not complained of pain. There is no documentation in R9's electronic medical record that R9's skin was assessed or treated by V15, LPN after the above interview. On 8/23/22 at 2:05 pm V2, DON stated "I was not aware that (R9) had a pressure area. It has not been reported, as far as I know. The CNA's (unidentified) should respond to (R9's) request for transfer from the bedside commode and report her complaints of pain from sitting. She will be assessed right away." R9's Nurse Note dated 8/23/2022 at 2:45 pm, documented by V3, Assistant Director of Nursing (ADON) documents the following "Health Status Note Text: This nurse (was) notified by (the) business office manager (V30) that resident (R9) had reported an open area to (R9's) coccyx to her (V3, ADON) at this time, upon assessment, resident observed to have blanchable redness to coccyx area measuring 5cm (centimeters) x 6cm (centimeters), (V3, ADON) spoke with resident (R9) regarding using protective cream to area (coccyx), resident (R9) stated that she would prefer to have a foam bandage applied to area, (V22, Medical Director) notified, order received	S9999		

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S9999	Continued From page 6 for Optifoam Gentle bordered foam, apply to coccyx, change every 3 (three) days et (and) PRN (as needed), if dressing becomes soiled or comes off, resident and husband notified of new orders, dressing applied to area." On 8/23/22 at 5:15 pm V3, Assistant Director of Nursing (ADON) stated "I (V3, ADON) did a skin assessment and found (R9) had redness to her coccyx region. We had only been applying ointment. (R9) wanted foam. I applied an Optifoam dressing and got an order from (V22, Physician). I measured the area and documented in the chart." (B) #2 Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at	S9999		

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S9999	Continued From page 7 least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. 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. Restorative measures shall include, at a minimum, the following procedures: 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. (Section 2-107 of the Act) These Regulations were not met as evidenced by:	S9999		

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S9999	Continued From page 8 Based on interview and record review the facility failed to ensure that a resident was secure in a wheelchair in the facility transport van for one of three residents (R72) reviewed for falls in the sample list of 47. This fall resulted in R72 being transported to the Emergency Room by the ambulance, sustaining a sprained ankle and injured finger requiring support bandage with splinting. Findings include: R72's Care Plan printed on 8/24/22 documents diagnoses including Bilateral Primary Osteoarthritis of the Knee, Spinal Stenosis, Lumbosacral Region, Muscle Weakness, Difficulty in Walking, History of Falling, Multiple Sclerosis, Morbid Obesity and Pain in Leg. This Care Plan documents R72 is at risk for falls related to impaired mobility with a revised date of 7/30/19. R72's Care Plan documents R72 has an ADL (Activities of Daily Living) Self Care Performance Deficit related to impaired mobility dated 4/30/2019 and documents R72 requires total assist of two staff participation with transfers using a full mechanical lift dated 4/30/2019. R72's Minimum Data Set (MDS) dated 2/4/22 documents R72 is cognitively intact and required total assist of two staff for transfers and total assist of one staff for locomotion. On 8/22/22 at 10:03 AM, R72 stated about six months ago R72 slid out of the wheelchair in the facility van. R72 stated that R72 injured R72's ankle and finger. R72's finger is crooked at the end after the last knuckle.	S9999		

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S9999	Continued From page 9 R72's Occurrence Report dated 3/3/22 documents a fall occurred off premises. This report documents R72 slid from R72's wheelchair during transport back to the facility following an appointment. (V24) Transport Aide reports that (R72) c/o (complained of) foot being uncomfortable during transport and as (V24) slowed down to turn, (R72) fell out of (R72's) wheelchair. (R72) was taken to local ED (Emergency Department) for evaluation. This Report documents R72's statement of what happened as staff at the hospital did not put (R72's) bottom far enough back when they assisted (R72) to the wheelchair. They told (R72) was far enough back. While in the van, (R72) felt like (R72) was sliding down. Reported to transport aide (V24) that (R72's) foot was uncomfortable and as the van began to turn, (R72) slid out of (R72's) wheelchair. On 8/24/22 at 11:43 AM, V2 Director of Nursing stated R72 went out for an infusion and V2 stated R72 told the hospital that R72 was not positioned correctly in the wheelchair and the hospital repositioned R72 and told R72 that R72 was positioned fine. V2 stated R72 told V24 that R72 had the hospital reposition R72 because R72 did not feel positioned correctly in the wheelchair. V2 stated that R72 told V24 that R72 felt like R72 was sliding out of the wheelchair. V2 stated V24 pulled over but R72 was already out of the wheelchair on the van floor. V2 stated V24 is not a CNA (Certified Nursing Assistant) so V24 cannot reposition R72. V2 stated if V24 felt like something was wrong V2 would expect V24 to call the facility. V2 stated as soon as V24 called V2, V2 went to the scene. V2 stated that the ambulance took R72 to the Emergency Room and performed X-rays. V2 stated that there were no fractures but they applied an elastic wrap on	S9999		

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S9999	Continued From page 10 R72's sprained ankle and a splint on R72's injured finger. V2 stated that they determined the cause of the fall was the way that R72 was positioned in the wheelchair. V2 stated they applied a foot cradle to the wheelchair to help prevent it from happening again. On 8/24/22 at 11:57 AM, V24 Transport Aide stated that they were on their way back to the facility from R72's infusion appointment. V24 stated that R72 told V24 that R72 felt like R72 was slipping and R72's foot was uncomfortable. V24 stated that R72 bent forward to try to do something with R72's foot. V24 stated R72 took R72's seatbelt off to reach R72's foot. V24 stated that R72 told V24 R72 felt like R72 was slipping. V24 stated that V24 told R72 that R72 was fine and that R72 wasn't going to slip out of the wheelchair. V24 stated that V24 told R72 that it was just that the sling was underneath R72. V24 stated R72 told V24 that R72 told the hospital that R72 did not feel far enough back in the wheelchair. V24 stated that R72 was too big for V24 to move. V24 stated that R72 appeared stable enough to make the ride back to the facility. V24 stated that V24 was making a turn when R72 started to slide out of the wheelchair. V24 stated that V24 pulled over immediately and called 911. V24 stated that V24 was fairly new and was sure that V24 fastened R72 in the van correctly. R72's Emergency Room Discharge Instructions dated 3/3/22 documents diagnoses of Fall, Ankle Sprain, Knee Pain, Finger Injury and Hip Pain. Instructions were to rest, take Tylenol as needed for pain, ice the affected area, wrap an elastic bandage on ankle, elevate ankle, wear splint on finger, follow up with orthopedics. R72 was given one Norco 5-325 mg (milligram) (narcotic pain	S9999		

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S9999	Continued From page 11 reliever). R72's Physician visit dated 3/8/22 by V22 Physician documents R72 had a fall out of the wheelchair after recent injection injured right ankle, also injured long finger on right hand. Has a splint on the finger. Appears R72 may have a mallet finger. (B)	S9999		