(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
			A. BUILDING:				
IL6005888		B. WING		07/12/2024			
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
MATTOO	N REHAB & HCC		TH NINTH N, IL 61938				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
S 000	Initial Comments		S 000				
	Annual Health Surv	rey					
S9999	Final Observations		S9999				
	Statement of Licens 300.1210b) 300.1210d)2)3)	sure Violations					
	Section 300.1210 Nursing and Person	General Requirements for nal Care					
	care and services to practicable physica well-being of the re- each resident's con- plan. Adequate and care and personal of	shall provide the necessary o attain or maintain the highest I, mental, and psychological sident, in accordance with apprehensive resident care I properly supervised nursing care shall be provided to each e total nursing and personal esident.					
	nursing care shall in	subsection (a), general nclude, at a minimum, the be practiced on a 24-hour, basis:					
		nts and procedures shall be dered by the physician.					
	resident's condition emotional changes determining care re further medical eva	bservations of changes in a , including mental and , as a means for analyzing and equired and the need for lluation and treatment shall be aff and recorded in the record.					

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 08/01/24

TITLE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6005888	B. WING		07/1	2/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-		
MATTOC	N REHAB & HCC	2121 SOU	TH NINTH				
WATTOC	N KLIIAD & 1100	MATTOON	N, IL 61938				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
S9999	Continued From pa	ge 1	S9999				
	These requirements by:	s were not met as evidenced					
	review the facility fa ordered diagnostic of two residents (RS Infections on the sa extended R5's suffe the following symptom	on, interview, and record illed to obtain a physician's test in a timely manner for one of reviewed for Urinary Tract imple list of 49. This failure ering for a total of six days with oms: painful and burning all pressure, and overall					
	Findings Include:  R5's Medical Diagnoses list dated July 2024 documents R5 is diagnosed with Bipolar Disorder, Depression, and Neuromuscular Dysfunction of Bladder.						
	R5's Minimum Data R5 is cognitively into	Set dated 6/13/24 documents act.					
	Recommendation ( Form and Progress documents R5 com burning and pain wi Director was notified	kground, Assessment, and SBAR) and Communication Notes dated 6/30/24 plained of abdominal pain and th urination. V17 Medical d and ordered a urinalysis and ity to be collected and sent to					
	urine was not sent t	dated 7/3/24 documents R5's to the lab until 7/3/24. R5's sensitivity Lab finally resulted					
	Recommendation (	kground, Assessment, and SBAR) and Communication Notes dated 7/6/24					

Illinois Department of Public Health

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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED	
IL6005888		B. WING		07/12/2024			
	PROVIDER OR SUPPLIER  ON REHAB & HCC	2121 SOU	DRESS, CITY, S TH NINTH I, IL 61938	STATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE	
\$9999	documents R5 state Infection (UTI) symany treatment. R5 tenderness and bur symptoms have go to the emergency roemergency room.  R5's Health Status R5 returned from the admitted with a Urin returned to the facil Central Catheter (Pintravenous antibion on 7/09/24 at 1:16 symptoms of an UT told the nurse and a however it took may and then it took six the sixth day there so R5 requested to R5 stated she was UTI, had a PICC lin were started. R5 stated she was UTI, had a PICC lin were started. R5 stated she was UTI, had a PICC lin were started. R5 stated she was UTI, had a PICC lin were started and was tired in the sixth of the sixth day there is the sixth of the sixth day there is the sixth day there is the sixth day there is the sixth day the started and was tired on 7/12/24 at 12:06 confirmed his experimplement new ord urinalysis should have 6/30/24- the day it valuer. V17 confirmed culture and sensitive urinary tract infections and the source of the sixth	ed she has had Urinary Tract ptoms and she has not gotten stated she has abdominal ring with urination and tten worse. R5 requested to go bom. R5 was sent to the  Note dated 7/8/24 documents he hospital after being hary Tract Infection. R5 ity with a Peripherally Inserted ICC) line and orders for tics.  PM R5 stated she first had I on Saturday (6/30/24). R5 an urine culture was ordered hy days for it to be completed days to get results back. On was still no treatment started go to the emergency room. admitted to the hospital with a le inserted and antibiotics ated she had abdominal holoating and pain for six days to treatment. R5 stated she dishe knew she needed to be	\$9999				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMF	(X3) DATE SURVEY COMPLETED	
		IL6005888	B. WING		07/1	2/2024
	PROVIDER OR SUPPLIER	2121 SOU	DRESS, CITY, S ITH NINTH N, IL 61938	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
\$9999	to the emergency ro and was diagnosed	ge 3 pom for treatment on 7/6/24 with a urinary tract infection is with intravenous antibiotics.	S9999			

Illinois Department of Public Health

STATE FORM 6899 WX7G11 If continuation sheet 4 of 4