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 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MATTOON REHAB & HCC	2121 SOUTH NINTH MATTOON, 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
S 000	Initial Comments Investigation of Facility Reported Incident of 10/8/24 / IL179780	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)6) 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. These requirements were not met as evidenced by:	S9999		

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S9999	Continued From page 1	S9999		

Based on interview and record review the facility failed to provide a safe transfer of a resident (R1) when assisting the resident to transfer into bed. This failure resulted in R1 sustaining a right shoulder dislocation which required overnight hospitalization and a surgical intervention. R1 is one of four residents reviewed for accidents on the sample list of four.

Findings Include:

The facility Incident Report Investigation dated 10/9/24 documents on the morning of 10/9/24 R2 complained of pain in her right shoulder and was sent to the emergency room for evaluation. R2 stated she believed the injury occurred when a staff member (V4 Certified Nurses Assistant) CNA from the evening prior transferred her into bed. R2 was found to have a right shoulder dislocation that required surgical intervention.

R2's Hospital Report dated 10/9/24 documents R2 presented to the emergency room with right shoulder pain and was found to have a right shoulder dislocation. R2 stated the pain began the night prior when staff moved her into the bed.

R2's Medical Diagnoses list dated October 2024 documents R2 is diagnosed with Muscle Weakness, Unsteadiness on Feet, Repeated Falls, Reduced Mobility, and Dislocation of Right Shoulder Joint.

R2's Minimum Data Set dated 10/3/24 documents R2 has a mild cognitive impairment and requires substantial maximal assistance from staff for transfers.

R2's Transfer Status dated 10/1/24 documents

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S9999	Continued From page 2	S9999		

R2 requires two staff persons for transfers and toileting.

On 10/24/24 at 3:28 PM R2 stated her right shoulder became dislocated a second time after V4 CNA transferred her into bed for the night. R1 stated V4 transferred her alone with no gait belt. R2 stated V4 must've pulled on her arm or moved it wrong. R2 stated her pain intensified over the next fifteen minutes and she was soon in extreme pain. R2 stated the pain continued into the morning. She was then transferred to the hospital and was diagnosed with a right shoulder dislocation which required surgical intervention.

On 10/25/24 at 10:19 AM V4 CNA stated she took care of R2 on the evening of 10/8/24. V4 stated she helped transfer R2 to and from the toilet and then also from the wheelchair to her bed for the night. V4 stated at the time of both transfers R2 did not have a sling on her right arm. V4 stated she was unsure if R2 was supposed to be wearing the sling but V4 denied clarifying to be sure. V4 stated she assisted R2 with no other help from staff and she did not use a gait belt during either transfer.

On 10/25/24 at 11:35 AM V6 Registered Nurse stated she took care of R2 during the day on 10/8/24 and on 10/9/24. V6 stated when she came on shift at 6:00 AM on 10/9/24, R2 was in extreme pain. At about 6:30 AM, V6 assessed R2's right shoulder and it appeared out of place. R2 was sent to the emergency room for evaluation. V6 stated when she was assessing R2's pain/shoulder, R2 stated her shoulder started hurting after she was transferred into bed the night before. V6 stated the day prior (10/8/24) R2's shoulder was not in any pain.

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S9999	Continued From page 3 On 10/25/24 at 11:40 AM V13 Registered Nurse stated shortly after she came on shift at 10:00 PM on 10/8/24 R2 stated the staff who put her to bed had pulled on her right arm and it started hurting after that. R2 rated her pain as a 8/10 and requested Tramadol for pain, which was administered. V13 stated when she followed up with R2 a bit later, she was asleep. V13 stated at about 5:00 AM on 10/9/24 R2 woke up and was in extreme pain, again rating it as a 8/10. V13 again administered Tramadol. On 10/25/24 at 10:25 AM V8 Physical Therapist stated initially R2 was admitted for therapy after a fall at home which resulted in some foot fractures and a dislocation of her right shoulder. R2 had a sling on when she was admitted which she was to wear at all times. R2 was not allowed to use her shoulder or lift her arm at all. She should not have been transferring without her sling on or using her arm to stabilize herself at all. V4 CNA should have checked with nursing if she was not sure if R2's sling needed to be on or not. V4 should have used a gait belt when transferring R2. According to V8's assessment a week prior on 10/1/24 R2 required two staff for transfers in order to prevent falls/injury. V8 stated if R2 was not wearing the sling, used her arm in any way or V4 CNA pulled on her arm, even if by accident- it would have caused the re-dislocation to occur. On 10/25/24 at 2:00 PM V1 Administrator confirmed facility staff should ensure resident safety by following the plan of care for safe transfers in order to avoid injury. (A)	S9999		