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 05/09/2019

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 Complaint #1963156/IL11180	S 000		
S9999	Final Observations Statement of Licensure Violations. 300.610 a) 300.1210 b)5) 300.1210 d)6) 300.3240 a) 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 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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resident to meet the total nursing and personal care needs of the resident.

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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.

These regulations were not met as evidenced by:

Based on record review and interview, the facility failed to transfer a resident (R4) using two assists. These failures resulted in R4 being lowered to the floor and sustaining a laceration to the left foot requiring emergency services and sutures. R4 is one of three residents reviewed for incidents and accidents in the sample of five.

Findings include:

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R4's Physician Order Sheet (POS) dated May 2019 includes the following diagnoses: Peritonitis, Insulin Dependent Diabetes Mellitus, End Stage Renal Disease, Peritoneal Dialysis, Difficulty in Walking, Obesity and Muscle Weakness. This same POS documents an admit date of 2/22/19.

The Resident Assessment Instrument (RAI) dated 3/1/19, 3/8/19 and 3/22/19 all document R4 as being cognitively intact and needing the extensive assistance of two persons for transfers. R4's 3/22/19 RAI documents R4 is not steady when moving from a seated to standing position or when turning around and is only able to stabilize with staff assistance.

The facility Fall Risk Assessment dated 2/22/19 documents R4 as being High Risk for falls due to History of Falls in the last six months. R4 is unable to independently come to a standing position, exhibits loss of balance while standing, requires hands-on assistance when moving from place to place, and has a decrease in muscle coordination. There were no other Fall Assessments prior to R4's 3/25/19 fall in R4's Medical Record.

A facility Incident/Occurrence Investigation report dated 3/25/19 at 7:45AM documents R4 being lowered to the floor by V5 (Certified Nursing Assistant) during a transfer from a wheelchair to the facility weight scale. The report states R4 became unsteady and weak and was lowered to floor. The same report documents a laceration to R4's left foot requiring evaluation and treatment at the local hospital Emergency Room (ER).

R4's Emergency Room Notes dated 3/25/19 at 10:20AM document the following: "Patient is seen in ER with complaints of fall and left pinky

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injury. (R4's) foot is covered at this time. The patient was seen and examined and has a laceration to the fifth and fourth digits on the plantar aspect of the left foot. The patient had an x-ray performed. The wound was cleansed with normal saline irrigation under pressure. Wound was repaired with 11 sutures to the 5th digit and 3 sutures to the 4th digit. Sterile dressing was applied. Patient was placed on Keflex 500 milligrams four times daily for secondary prophylaxis against infection due to location of wound and patient being diabetic. Patient was placed in a surgical shoe. X-rays read by radiology demonstrates no acute fracture, mildly displaced fracture of the fifth digit proximal phalanx age-indeterminate possibly chronic. (R4) was advised to follow up with orthopedic on call, (V8 Orthopedist), in the next 2-3 days for evaluation of the toe."

A statement provided by V5 on 3/25/19 documents the following: "The nurse unhooked the resident (R4) and I got (R4) into the wheelchair and took (R4) to the shower room to get R4's weight. The nurse stated that the resident (R4) needed to stand to be weighed. The resident is a 1 (one) assist with transfers. The resident was wearing slipper socks at the time of transfer. Resident has been wearing slipper socks since (R4's) feet are swollen. When we got to the shower room, I assisted resident to stand and turn onto the scale. After resident turned, (R4's) left knee buckled. I was behind R4 and was able to lower R4 to the ground. "

A statement provided by V11, Licensed Practical Nurse on 3/25/19 includes the following: (V5) took (R4) to the shower room to weigh (R4) after I (V11) unhooked (R4) from (R4's) dialysis. I heard (V5) yell for help and entered the shower room to

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find (R4) sitting in the floor with (R4's) feet in front of (R4), facing the wheelchair. During my assessment I noticed blood on the bottom of (R4's) left slipper sock. Upon removal of the sock, I observed a laceration to the underneath of (R4's) 4th and 5th toes. I immediately applied a pressure dressing and notified the (Medical Doctor) and received orders to send (R4) to the ER for evaluation."

A statement provided by V2, Director of Nursing includes the following: "During assessment of (R4's) wheelchair to establish how (R4) received the laceration, I noted a rough area on top of the metal holder on the front right wheel. There weren't any noted rough areas to the left front wheel or bilateral pedal holder. After speaking with staff and reviewing where all equipment was placed and how (R4) was facing, it appears that this rough area on the front of the wheel housing is the reason for the laceration."

On 5/8/19 at 2:00PM, V5 confirmed R4 had fallen while V5 was trying to get a weight. V5 acknowledged V5 was the only staff member transferring R4 at the time of the fall. V5 also acknowledged at this time that R4 is sometimes weak and if there had been two staff assisting R4, they would have had better control during the transfer and R4 may not have fallen.

On 5/9/19 at 10:20AM, R4 stated V5 did not use a gait belt when transferring R4 to the weight scale. R4 stated V5 asked R4 to step onto the scale from V5's wheelchair. R4 stated "I started to step onto the scale, it all happened so fast I fell." R4 stated "I had to have 14 stitches in my foot. It set me back 2 weeks." R4 stated the wheelchair R4 uses belongs to the facility.

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S9999	Continued From page 5 On 5/9/19 at 11:15AM, V6 (Primary Care Physician) stated R4 should have had two staff members transferring R4 and holding R4 in a standing position to get a weight. V6 stated after residents receive dialysis, any kind of dialysis, they are weak. V6 stated the injury could have been prevented. V6 also agreed R4's injury did indeed cause a setback in R4's rehabilitation. On 5/9/19 at 11:45AM, V2 confirmed R4's wheelchair was facility equipment. At this same time V1 stated the facility did not have a policy on maintenance of facility wheelchairs. (B)	S9999		