Illinois Department of Public Health

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 02/28/2024

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	S 000		
	Investigation of Facility Reported Incident of January 29, 2024/IL169939			
S9999	Final Observations	S9999		

Statement of Licensure Violations:

300.1210a)
300.1210b)4)
300.1210c)
300.1210d)6)

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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

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S9999	Continued From page 1	S9999		

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:

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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:

Based on observation, interview, and record

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S9999	Continued From page 2	S9999		

review, the facility failed to safely transfer R1 to prevent a traumatic fall. This failure resulted in R1 falling face first into the ground causing a forehead laceration requiring 15 sutures at the hospital emergency department. R1 is one of three residents reviewed for accidents in the sample of three.

Findings include:

R1's medical diagnosis list (2/23/2024) documents R1's diagnoses include: Difficulty in Walking, Reduced Mobility, Muscle Weakness, Apraxia (difficulty with skilled movements even when a person has the ability and desire to do them), Unspecified Abnormalities of Gait and Mobility, History of Transient Ischemic Attack (a temporary disruption in blood flow to the brain) and Cerebral Infarction (partial brain tissue death due to disruption in blood flow), Mild Cognitive Impairment, and Expressive Language Disorder.

R1's comprehensive assessment (11/17/2023) documents R1 has severe cognitive impairment and requires staff assistance to complete activities of daily living. The same record documents R1 requires staff assistance to transfer from a bed to a chair and uses a wheelchair for mobility.

R1's Fall Risk assessment 1/5/2024 documents R1 is at a high risk for experiencing falls.

The facility fall investigation (1/29/2024) documents V8 (Certified Nurse Aide) was transferring R1 from R1's bed to R1's wheelchair on 1/29/2024 when R1 fell face-first onto the floor resulting in lacerations to R1's right forehead requiring emergency transfer to the hospital for evaluation and treatment.. The same record

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S9999	Continued From page 3	S9999		

documents V8 did not use a gait belt during the transfer of R1 from R1's bed to R1's wheelchair.

The facility incident report (2/5/2024) documents R1 sustained a fall the ground on 1/29/2024 resulting in an a forehead laceration requiring emergency medical treatment at the hospital. The report further documents R1 returned the same day from the hospital, was assessed for safety, and R1's care plan was updated.

R1's care plan (1/15/2024) in effect at the time of R1's 1/29/2024 fall documents R1 is at high risk for experiencing falls. The same record documents facility staff added the fall prevention interventions "Use of gait belt with all transfers" and "Re-educate Staff on Use of gait belt with all transfers" to R1's care plan on 1/30/2024. The care plan does not document the facility revised R1's care plan with any other additional fall prevention interventions in the one-week period immediately following R1's 1/29/2024 fall.

R1's pain assessment (1/29/2024) documents R1 experienced aching and throbbing pain to R1's to face, neck, and left hand after R1's fall on 1/29/2024.

R1's emergency room hospital report (1/29/2024) documents R1 had a witnessed fall from the wheelchair in the nursing home on 1/29/2024 resulting in a stellate (a radiating pattern like a star) forehead laceration requiring 15 sutures. The same record documents R1 received intravenous pain medication when the emergency department sutured R1's forehead laceration.

On 2/27/2024 at 9:20AM, V8 reported assisting R1 transfer from R1's bed to R1's wheelchair on 1/29/2024 and when R1 was almost seated in the

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S9999	Continued From page 4	S9999		

wheelchair, R1 "lunged forward" and fell to the ground. V8 alleged V8 was using a gait belt on R1 at the time of the transfer, but the gait belt slipped from V8's hands when R1 fell. V8 reporting removing R1's gait belt after the fall and then rolling R1 face up before providing additional care to R1 while waiting for emergency medical services to arrive to transport R1 to the hospital.

On 2/23/2024 at 1:41PM, V2 (Director of Nursing) reported previously investigating R1's 1/29/2024 fall, and during the investigation, V8 had performed a demonstration of how R1 allegedly fell to the ground during a transfer from R1's bed to R1's wheelchair. V2 reported V8 had described and demonstrated how R1 was sitting on the edge of R1's bed and then assisted R1 to transfer to R1's wheelchair positioned adjacent to the bed, with V8 located on the opposite side of R1's wheel chair. V2 reported V8 said when R1 was transferred and seated in R1's wheelchair, R1 then leaned forward and fell to the ground. V2 reported V8 did not say whether or not V8 was using a gait belt during the transfer.

V2 reported being present in R1's room after the fall and staying with R1 until the ambulance arrived and R1 remained face down on the floor and R1 was not rolled over until emergency medical services staff rolled R1 over before transport to the hospital. V2 reported R1 did not have a gait belt on during V2's observations. V2 denied R1 has a history of leaning forward while R1 is seated in R1's wheelchair.

V4's (Certified Nurse Aide) witness statement (1/29/2024) documents V4 observed R1 on the floor in R1's room "in a pool of blood" after R1's fall on 1/29/2024.

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S9999	Continued From page 5	S9999		

On 2/27/2024 at 1:35PM, V4 reported going into R1's room on 1/29/2024 and discovering R1 had sustained a fall and was on the floor with a head laceration and was bleeding and moaning. V4 reported observing R1 face down without a gait belt on, and V8 was present with R1. V4 reported a prior history of providing nursing care to R1 and never seeing R1 lean forward and also never having a gait belt slip from V4's hands during V4's 14 year history of providing cares for residents in nursing facilities.

On 2/27/2024 at 2:37PM, R1 was laying in bed and had a jagged forehead laceration, appearing several inches in length and purple in color, located above R1's right eyebrow. The laceration resembled the shape of a branched lightning bolt.

"B"