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	145480	A. BUILDING _____ B. WING _____	10/21/2011

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MATTOON HEALTHCARE AND REHAB CTR	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) COMPLETION DATE
F 000	INITIAL COMMENTS Annual Licensure and Certification Survey Licensure Survey for Subpart S: SMI	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and	F 225		10/25/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 225	Continued From page 1 certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that an allegation of theft was documented, thoroughly investigated, and reported to the State Survey and Certification Agency. The failure affected one supplemental resident (R33). In addition facility staff failed to report an allegation of abuse concerning R11 to the Administrator and failed to follow facility policy by not suspending the alleged perpetrator from resident contact. R11 is one of one resident reviewed for an abuse allegation in the sample of fifteen. Findings include: 1. On 10-19-11 at 10:40 a.m. R33 stated that she had $30.00 cash taken from her room following the Christmas holiday 2010 and that she had reported it to facility staff including the Administrator. R33 stated that she believed the theft had been investigated and that she had been reimbursed for the missing money. R33 stated she believed that an employee had taken her money from her bedroom. R33 stated that the employee no longer worked at the facility. On 10-19-11 at 2 p.m. E1, Administrator stated that there was no documented evidence that such an investigation was completed or reported to the State Survey and Certification Agency. E1 stated	F 225		

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F 225	Continued From page 2	F 225		

that the former Administrator was questioned about the allegation and replied that it had been investigated as a "grievance" and R33's money was reimbursed. E1 stated that there was no documentation of the grievance or corresponding investigation. E1 stated that the allegation and investigation should have been documented and handled differently.

The facility policy states, "...Once the Administrator or designee determines that there is a reasonable cause for possible mistreatment, the Administrator or designee will appoint a person to take charge of the investigation...The appointed investigator will follow the Resident Protection Investigation Procedures, attached to this policy. The Procedures contain specific investigation paths depending on the nature of the allegation, and procedures for investigation, interview parameters, and reporting requirements..."

2. The October 2011 Physician's Orders show R11 has diagnoses of History of a Fractured Hip and Depression. R11 is identified by the facility as being an interviewable resident. The facility document "...Final Incident Investigation Report ...." not dated, reads as follows: "...On 8/10/11 @ 1745 (5:45 PM), resident (R11) reported that a CNA (Certified Nursing Assistant) (E10) was "mean" to her. She stated the incident occurred before supper on 8/10/11, that the CNA jerked her blankets off and told her to get out of bed, and CNA made her wheel herself to the dining room...The resident's perception was that the CNA was rude and inappropriate toward her..."

A statement written by E8, Licensed Practical

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Nurse (LPN) reads as follows: "...Conversation between this nurse and resident (R11), that occurred on 8/10/11 @1745 (5:45 PM). As I was pulling away from the DR (dining room) (with) my med cart, resident (R11) tugged on my shirttail. Resident asked if I saw the CNA (E10) that just left the dining room. I said yes (E10). Resident (R11) stated she (E10) was mean to her. I asked how. Resident stated "she ripped my blankets off and told me to get out of bed. I told her I didn't feel good, I had just had therapy..." I (E8 LPN) went to (E9 Registered Nurse), RN, and told her resident's complaints..."

R11 stated on 10/20/2011 at 3:30 PM that this incident happened and that she reported it to the nurse.

E1, Administrator stated on 8/20/2011 at 3:00 PM that neither E8 LPN nor E9 RN had reported the incident to her (E1) on 8/10/11 as required by facility policy. E1 stated the accused (E10) continued to work her entire shift the night of 8/1/2011. E1 stated both E8 and E9 received written warnings as discipline.

The Archived Time Card Report for E10 dated 8/10/2011 documents E10 clocked into work at 1:59 PM and clocked out to go home at 10:25 PM. The comparison of the two reports showed E10 worked 4 hours and 40 minutes after the allegation of abuse was reported to E8 LPN.

Facility policy states, "...Employees are required to report any occurrences of potential mistreatment they observe, hear about, or suspect to a supervisor or the Administrator..." The policy also states, "...Employees of this

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F 225	Continued From page 4 facility who have been accused of mistreatment will be removed from resident contact immediately until the results of the investigation have been reviewed by the Administrator or designee. Employees accused of possible mistreatment shall not complete the shift as a direct care provider to residents..."	F 225		
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to have an Abuse Prohibition policy that requires immediate reporting of abuse allegations to the Administrator. In addition the Abuse Policy does not require supervisors to report allegations of abuse. This has the potential to affect all 67 residents in the facility. Findings include: The facility abuse policy shows the following: Under the heading "...IV INTERNAL REPORTING REQUIREMENTS AND IDENTIFICATION OF ALLEGATIONS...Employees are required to report any occurrences of potential mistreatment they observe, hear about, or suspect to a supervisor or the Administrator..."	F 226		10/25/11

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F 226	Continued From page 5 On 10/21/11 at 11:00 a.m. E1, Administrator, confirmed this was the abuse policy which was currently in place. The Resident Census and Conditions of Residents lists a current census of 67 residents.	F 226		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to have staff present in the room to supervise R14 when R14 was in a geriatric reclining chair. R14 was left unattended and sustained a fall resulting in fracture right shoulder. In addition the facility failed to utilize foot rests when transporting R8 in a wheelchair. R14 and R8 are two of seven residents reviewed for falls in a sample of 15. Findings include: 1. The Physician's Order Sheet (POS) dated October 2011 lists the following diagnoses for R14: End Stage Renal Disease and Seizure Disorders. The Minimum Data Set (MDS) dated 5/6/11 states that R14 is cognitively intact and is totally dependent on staff for all activities of daily	F 323		10/25/11

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living to include bed mobility, transfers and toilet use. The MDS states R14 requires two plus person physical assist for all activities, has impairment on both sides for upper extremities and impairment on one side for lower extremities. The same MDS states that R14 had a fall with major injury prior to admission. Fall risk assessments dated 5/6/11 and 7/16/11 state R14 is a high risk for falls.

Facility report titled "Incident Report"dated 5/3/11 in the section titled "Description of Events" states R14 was sitting in a reclining geriatric chair and attempted to transfer self to the bed and was found on the floor. The section of the same report titled "Recommendations/Interventions" states : "(R14) is not to be left in room while up in reclining geriatric chair. Chair alarm and bed alarm placed."

An x-ray report dated 5/3/11 for R14 states under the section titled "Findings" reads " A complete fracture through the left proximal humerus is identified...."

Facility report titled "Incident Report" dated 5/19/11 in the section titled "Description of Events" states R14 was sitting in the reclining geriatric chair and attempted to transfer self and was found on the floor.
The section of the same report titled "Recommendations/Interventions" states: R14 to be in visual range of staff when up in reclining geriatric chair.

An x-ray report dated 6/2/11 for R14 states under the section titled "Findings" reads "Irregularity of the right humeral head is noted. A complete

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F 323	Continued From page 7 oblique fracture is noted through the midshaft of the right humerus...." R14's care plan dated 5/3/11 under the section titled "Fall Prevention Care Plan - High Risk" under "Interventions: states "Resident not to be left in room when up in reclining geriatric chair... On 10/21/11 at 2:10 PM E14, Licensed Practical Nu (LPN) stated that R14 was left alone in her reclining geriatric chair, fell and ended up with fracture to her right shoulder. 2. The Interdisciplinary Team (IDT) Plan of Care Meeting documents that on 5-19-11 at 11:00am E8, LPN was pushing R8 down the hall in his wheelchair without foot pedals. This report stated R8 put his foot down causing the left ankle to roll. "Pain and bruising noted to the left ankle. X-ray obtained and no fracture noted." E15, Certified Nurses Aide at 3:15pm on 10-20-11 and E14, LPN at 3:25pm on 10-20-11 each stated R8 did not have foot pedals on his wheel chair until after the incident of 5/19/11. The IDT Plan of Care Meeting report shows the foot pedals on the wheelchair and were implemented on 5-19-11.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		10/25/11

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This REQUIREMENT is not met as evidenced by:
Based on interview, record review and observation the facility failed to ensure the cold water chemical dishmachine was functioning properly for adequate sanitization after the cleaning cycle. This failure has the potential to affect all 67 residents in the facility.

Findings include:

On 10-19-11 at 9:45am E12, Dishwasher and E13, Dietary Aide were processing dishes using a cold water dishmachine. E13 identified they check the machine with the test tapes. E13 first used Quaternary Ammonium test strip which did not change, then tried the test tape for Bleach. This time the test tape changed a slight yellow color. E11, Dietary Manager was called over to check out the machine.

In the meantime E12 and E13 were asked if either had ran a test tape prior to doing dishes this morning and both said, "No". E13 stated, "It is her job (E12) to do it. (E12) usually does it every morning. This was the first time I did it. "

E11, Dietary Manager came over to the machine, shook the bucket of sanitizer and noted the bucket was almost empty and pushed the tubing down into the bucket further. E11 told staff to get a new bucket of sanitizer. E11 then ran another cycle before checking again. The test strip showed 50 parts per million (ppm) this time. E11

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F 371	Continued From page 9 stated staff are to check the sanitizer daily prior to each meal and document. E13 stated, " We didn't this meal." The report from the chemical supply vendor dated 10-20-11 verified the dish machine was "not sanitizing." The Resident Census and Conditions of Residents lists a current census of 67 residents.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441		10/25/11

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F 441	Continued From page 10 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that effective decontamination procedures were being used to eliminate known infectious pathogens within the facility, specifically Clostridium difficile (C. diff). These failures affect 2 of 3 residents sampled for infection control on the sample of 15 (R6 , R7). The facility also failed to ensure that reusable utensils and equipment being used in the beauty shop are effectively decontaminated after each use. These failures potentially affect each of the 19 residents using the beauty shop (R6, R7, R16-R32). Findings include the following: 1. On 10-19-11 at 2:30 p.m. E3, Housekeeping Supervisor stated that she was aware of 2 residents with Clostridium difficile infection (R6, R7) and that targeted interventions were being used to decontaminate high touch surfaces within the bedrooms of those individuals. E3 stated that a disinfectant/cleaner was being used to decontaminate these surfaces.	F 441		

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F 441	Continued From page 11 The disinfectant/cleaner being used, "Hospital Germicide Disinfectant Cleaner", a quaternary ammonia compound, bears no label claims as being effective against Clostridium difficile or its spores. E3 stated that she was not aware of any facility operating policy related to decontamination procedures to use to decontaminate environments with C. diff. E3 stated that the same chemical agent and procedures are used throughout the facility for all rooms. E4, Infection Control Coordinator stated on 10-19-11 at 2:45 p.m. that she was unsure if there was operating policies related to decontamination procedures for environments with C. diff. E3 stated that she believed this disinfectant/cleaner to be effective against C. diff. E3 stated on 10-19-11 at 2:50 p.m. that after checking with the chemical manufacturer, she was informed that the chemical agent being used is not formulated to be effective against C. diff. or its spores. E2, Director of Nursing stated on 10-19-11 at 1:50 p.m. that R6 remains in isolation for active signs and symptoms of C. diff infection and that R7 remains in isolation for chronic loose stools of unknown etiology. 2. On 10-18-11 at 1:15 p.m. E5, Hairdresser stated that she decontaminates combs and brushes following each use. E5 further stated	F 441		

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F 441	Continued From page 12 that she decontaminates hair rollers "once every 1 to 2 months" and permanent wave rods are decontaminated "once every 2 weeks". E5 stated that she decontaminates these utensils by soaking them in a disinfectant/cleaner solution. E5 stated that she decontaminates the electric clipper blades at the end of each day's use. E5 stated that hair rollers, permanent wave rods, and electric clippers are reused throughout each day on multiple residents. E5 stated she was unaware of any facility operating policy regarding decontamination procedures to use within the beauty shop for multi-use utensils and equipment. E2, Director of Nursing stated on 10-18-11 at 2:30 p.m. that she was unsure if there were any such infection control policies. E2 supplied an untitled document on 10-19-11 which states under "Patient Care Equipment and Articles...Noncritical equipment (i.e. equipment that touches intact skin) contaminated with blood, body fluids, secretions, or excretions is cleaned and disinfected after use..." A section titled "Patient-Care Equipment" states "...Ensure that reusable equipment is not used for the care of another patient until it has been cleaned and reprocessed appropriately..." E7, Accounts Payable Director supplied a Beauty and Barber Log from 10-18-11 which documents 19 residents receiving hairdresser services including R6, R7, and R16-R32.	F 441		
F9999	FINAL OBSERVATIONS	F9999		

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F9999	Continued From page 13 LICENSURE VIOLATIONS 300.1210b)5) 300.1210c) 300.1210d)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care \ 300.1210b)5) 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: 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. 300.1210c) c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 300.1210d)6) d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,	F9999		

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	145480	A. BUILDING _____ B. WING _____	10/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MATTOON HEALTHCARE AND REHAB CTR	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) COMPLETION DATE
F9999	Continued From page 14 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. 300.3240 Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. THIS REQUIREMENT IS NOT MET AS EVIDENCED BY: Findings include: Based on record review and interview the facility failed to have staff present in the room to supervise R14 when R14 was in a geriatric reclining chair. R14 was left unattended and sustained a fall resulting in fracture right shoulder. In addition the facility failed to utilize foot rests when transporting R8 in a wheelchair. R14 and R8 are two of seven residents reviewed for falls in a sample of 15. 1. The Physician's Order Sheet (POS) dated October 2011 lists the following diagnoses for R14: End Stage Renal Disease and Seizure Disorders. The Minimum Data Set (MDS) dated 5/6/11 states that R14 is cognitively intact and is totally dependent on staff for all activities of daily living to include bed mobility, transfers and toilet	F9999		

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F9999	Continued From page 15	F9999		

use. The MDS states R14 requires two plus person physical assist for all activities, has impairment on both sides for upper extremities and impairment on one side for lower extremities. The same MDS states that R14 had a fall with major injury prior to admission. Fall risk assessments dated 5/6/11 and 7/16/11 state R14 is a high risk for falls.

Facility report titled "Incident Report"dated 5/3/11 in the section titled "Description of Events" states R14 was sitting in a reclining geriatric chair and attempted to transfer self to the bed and was found on the floor. The section of the same report titled "Recommendations/Interventions" states : "(R14) is not to be left in room while up in reclining geriatric chair. Chair alarm and bed alarm placed."

An x-ray report dated 5/3/11 for R14 states under the section titled "Findings" reads " A complete fracture through the left proximal humerus is identified...." \

Facility report titled "Incident Report" dated 5/19/11 in the section titled "Description of Events" states R14 was sitting in the reclining geriatric chair and attempted to transfer self and was found on the floor.
The section of the same report titled "Recommendations/Interventions" states: R14 to be in visual range of staff when up in reclining geriatric chair.

An x-ray report dated 6/2/11 for R14 states under the section titled "Findings" reads "Irregularity of the right humeral head is noted. A complete oblique fracture is noted through the midshaft of

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	145480	A. BUILDING _____ B. WING _____	10/21/2011

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F9999	Continued From page 16 the right humerus...." R14's care plan dated 5/3/11 under the section titled "Fall Prevention Care Plan - High Risk" under "Interventions: states "Resident not to be left in room when up in reclining geriatric chair... On 10/21/11 at 2:10 PM E14, Licensed Practical Nu (LPN) stated that R14 was left alone in her reclining geriatric chair, fell and ended up with fracture to her right shoulder. 2. The Interdisciplinary Team (IDT) Plan of Care Meeting documents that on 5-19-11 at 11:00am E8, LPN was pushing R8 down the hall in his wheelchair without foot pedals. This report stated R8 put his foot down causing the left ankle to roll. "Pain and bruising noted to the left ankle. X-ray obtained and no fracture noted." E15, Certified Nurses Aide at 3:15pm on 10-20-11 and E14, LPN at 3:25pm on 10-20-11 each stated R8 did not have foot pedals on his wheel chair until after the incident of 5/19/11. The IDT Plan of Care Meeting report shows the foot pedals on the wheelchair and were implemented on 5-19-11.	F9999		