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 _____	07/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MATTOON REHAB & HCC	2121 SOUTH NINTH MATTOON, IL 61938

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S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 300.1210a) 300.1210b) 300.1210d)6) 300.3240a) 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 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	S9999		

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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 Requirements are not met as evidenced by:

Based on record review and interview the facility failed to provide safe transfers with mechanical lift as required and failed to implement planned interventions to prevent falls for for three of ten residents (R18, R24, R26) reviewed for falls on the sample of 18. Failure to transfer with mechanical lift resulted in R24 sustaining a fall with fracture.

Findings include:

1. The Care Plan dated 7/24/13 documents that R24 is at high risk for falls related to unawareness of safety needs, impaired thought processes and gait/balance problems. The Care Plan interventions document that a mechanical lift is to be used for transfers of R24.

The Occurrence Report dated 11/1/13 documents that on 10/26/13 at 6:45 am, E15 (Certified

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Nurses Aide) transferred R24 from bed to wheelchair using a one person pivot transfer technique. During the transfer R24's right leg crossed underneath R24, resulting in R24 saying "ouch." No further discomfort was voiced by R24 at that time. The incident was not reported by E15 until 11/1/13 when she was interviewed by E1 (Administration) for the investigation. E15 commented, "On October 26th, a Saturday, we had two aides on the hall. We were very busy that morning. I had to get (R24) out of bed.. . ".

E13 (Licensed Practical Nurse)stated on 7/17/14 at 2:00 pm that R24 complaint of right ankle pain 10/26/13 at 10:09 am. Upon questioning R24, E13 could not determine a specific cause for the discomfort. E13 then initiated an investigation for an injury of unknown origin. The physician was notified and an x-ray of the right lower extremity and foot was ordered. The x-ray showed "no acute findings of the right tibia, fibula, ankle, or foot."

The Nursing Notes for R24 on 10/28/13 document continued complaints of right lower extremity pain with bruising of the outer aspect of the right ankle. Tylenol (analgesic) was administered as ordered for pain with effective results on 10-28-13, 10-29-13, 10-30-13 and 10-31-13.

A second x-ray of the right lower extremity and right foot was ordered on 10-31-13. The Radiology Report of 10-31-13 documents a nondisplaced fracture of the distal fibula.

E1 (Administrator) stated on 7-17-14 at 2:00 pm that the incident investigation of 10/26/13 determined that R24 sustained a fracture because of an incorrect transfer. E15 did not use

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S9999	Continued From page 3 a mechanical lift. 2. The Care Plan dated 6/13/14 documents that R18 is at high risk for falls related to safety awareness, confusion, physical restraint use, gait/balance problems and incontinence. The Care Plan's interventions document that R18 uses an electronic alarm for her chair and bed and for staff to "ensure the device (alarm) is in place, turned on, and in working order." The Care Plan also documents "ensure (R18's) bed is in the lowest position when layed (laid) down." The Occurrence Reports dated 9/23/13,10/29/14, 11/14/13, and 2/7/14/ document that R18's alarm was not in place or not sounding at the time of the fall. The Occurrence Report dated 4/28/14 documents that R18's bed was not in the lowest position when R18 fell out of bed. The Occurrence Report dated 9/23/13 at 1:15 pm documents "(R18) attempted to transfer self and fell. Staff did not follow plan." R18's alarm was "not sounding." The reports documents "educated the CNA (E7) on ensuring alarms are on and in working order." The Occurrence Report dated 10/29/13 at 7:55 pm documents "(R18) attempted to get herself out of her bed and fell." The report documents that no alarm was in place at the time of R18's fall. The Occurrence Report dated 11/14/13 at 11:23 pm documents "(R18) rolled out of low bed and onto mat on the floor." The report documents that no alarm was in place at the time of R18's fall.	S9999		

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The Occurrence Report dated 2/7/14 at 3:40 pm documents "First shift did not place pressure alarm from wheelchair under the resident in bed. The report documents that no alarm was in place at the time of R18's fall and that the pressure alarm "was still in the wheelchair."

The Occurrence Report dated 4/28/14 at 1:28 pm documents "(R18) was in bed and attempted to get out of bed and sat on mat next to bed. . . .First shift did not place pressure alarm from wheelchair under the resident in bed. . . . bed was not put in the lowest position, disciplinary action initiated."

On 7/16/14 at 1:45 pm E12, Licensed Practical Nurse and Fall Prevention Coordinator acknowledged that R18's Plan of Care for fall prevention was not followed. E12 stated that alarms were not in place or not sounding when R18 fell on 9/23/13, 10/29/13, 11/14/13, and 2/7/14. E12 stated that R18's "bed was not at the very lowest position and it should have been" when R18 fell out of bed on 4/28/14.

On 7/17/14 at 1:15 pm E2, Director of Nursing, stated that the CNAs are responsible to check resident's alarms, placement and function.

3. The Physician Order Sheet dated July 2014 for R26 documents diagnoses of Pancreatic Cancer with Metastasis and Anxiety.The Plan of Care dated June 2014 documents that R26 is at risk for falls due to safety needs, confusion, psychoactive drug use and gait/balance problems. The same Plan of Care directs staff to use chair and bed electronic alarms.

The facility "Fall Details Report" documents R26

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S9999	Continued From page 5 with a fall from his bed on 6/10/14. The report documents staff finding R26 on the floor by his bed due to self-transferring. The intervention for this fall is "Pressure Alarm pad applied under resident at all times." R26 is documented as having another fall on 6/17/14. The Fall Details Report dated 6/17/14 documents that R26 was found lying supine on the floor at 9:45 pm. There were no electronic alarms in place for R26, per this report. On 7/17/14 at 10:55 am E12, Licensed Practical Nurse and Fall Prevention Coordinator stated "(R26) should have had alarms on his bed and chair on 6/17/14". (B)	S9999		