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 10/29/2014

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
S9999	Final Observations	S9999		

Licensure Violations:
300.610a)
300.1210d)6
300.3240a)

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
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 requirements are not met as evidenced by:

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Based on record review and interview, the facility failed to supervise a resident (R1) and operationalize their Door Alarm Policy. This failure resulted in R1 exiting the facility unattended, falling and sustaining a fracture. R1 is one of three residents reviewed for elopement (leaving the building unnoticed) in the sample of three.

Findings include:

The Physician Order Sheet (POS) for R1 dated October 2014 documents the following diagnoses: Altered Mental Status, Depression, Closed Fracture of Clavicle, Urinary Tract Infection and Symbolic Dysfunction. An order for Remeron 7.5 milligrams for R1's diagnosis of Depression is documented on the POS with a start date of 9/23/14.

The Minimum Data Set dated 9/19/14 documents R1's cognition as moderately impaired.

On 10/01/14, Nursing Notes document that R1 has inattention and disorganized thinking with short and long term memory problems. R1's Nursing Notes document that on 10/3/14 the facility received a phone call at 2:45 pm from Z1, Community Neighbor of R1. Nursing Notes go on to document that Z1 reported that R1 was at his house because R1's house was locked and R1 could not get in. The same Nursing Note documents that R1 left the facility on foot with a cane and R1 reported having a fall and complained of left shoulder soreness. The Nursing Note continues with documentation of an ambulance being contacted for transport of R1 to the local emergency room. There is no documentation in R1's facility Medical Record of

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S9999	Continued From page 2 R1 complaining of shoulder pain prior to 10/3/14. A Web based report titled "Weather History for Mattoon, Illinois" documents weather conditions for 10/03/14, giving the following statistics: Between the hours of 1:30 pm to 3:00 pm, the temperature recorded is documented at 62 degrees Fahrenheit. The same report records and documents a wind speed of 19 miles per hour with gusts reaching to 32 miles per hour. A Radiology Report dated 10/3/14 for R1 documents a left shoulder x-ray with the following findings: "There is a slightly displaced fracture involving the distal clavicle, best seen on lateral view...." The facility policy titled "Door Alarm Policy" and dated February 2007, documents the following: "Door alarms require immediate attention by facility staff, to insure the safety of all residents. The following procedures must be followed in relation to door alarms. Upon hire, all staff must be educated on the reason for door alarms as well as why an immediate response is crucial. Immediate response refers to any employee who immediately goes to the door that caused the alarm to sound. The employee must exit the facility and thoroughly search the surrounding area. It is not sufficient to search the surrounding area from within the facility.......When a door alarm sounds, the alarm is not to be silenced until the reason for the activation is determined. Staff must follow this procedure: Go directly to the door where the alarm is sounding. Check outside the door, do not assume anything......If the source of the activation is a visitor or a vendor, instruct them on how to properly and safely disarm the alarm before leaving the building....In regular monthly staff in-services , staff should continue to	S9999		

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be reminded of the importance of their immediate response to door alarm activation."

On 10/24/14 at 9:40 am, E1, Administrator acknowledged that R1 had left the facility unattended and three employees watched R1 leave but thought R1 was a visitor. The employees were identified by E1 as E3, Transport Aide, E4, Maintenance Assistant and E5, Nurse Practitioner. E1 acknowledged at this time that the three employees, E3, E4 and E5 did not follow the facility policy on Door Alarms. E1 stated R1 left the facility somewhere between 1:30 pm and 2:00 pm on 10-3-14. E1 stated "(R1) was last seen at 1:15 pm by staff."

On 10/24/14 at 11:30 am E3 stated that she did see R1 go by with a coat and cane. E3 stated she then heard the alarm go off and then it was silenced. E3 stated "I thought (R1) was a visitor and had set the alarm off, I did not go check on the alarm." E3 acknowledged that she had not followed the Door Alarm policy. E3 stated "I thought I was going to be fired for not following the policy and letting a resident get out the door."

On 10/24/14 at 12:20 pm E4 stated that he had been at the front door with his back to the door when R1 went out the door, appearing to him as a visitor. E4 stated that when E5 silenced the alarm he thought E5 knew who the person was. E4 acknowledged that E5 nor himself went outside to check with the person setting off the alarm and that he did not follow the facility Door Alarm policy. E4 stated "I should have investigated it or reported it, so as to make sure the person setting off the alarm was a visitor and not a resident."

On 10/24/14 at 1:00 pm, E5 stated she thought

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R1 was a visitor going out the door and just didn't know the door code. E5 stated "the alarm went off and I saw (R1) going down the sidewalk." E5 stated that R1 had on a jacket with a hood up over her head and R1 had a cane. E5 stated "I did not see her face, (R1) had the hood of her coat up and she looked like a visitor from behind, it was windy that day." E5 stated she silenced the alarm. E5 acknowledged that she did not follow the facility Door Alarm policy. E5 stated "I should have went out side and asked her what her name was again, or something like that...."

On 10/24/14 at 1:35 pm Z2, family member stated that R1 lived one and a half mile from the facility and R1 would have to cross railroad tracks and a busy street to reach her house. Z2 stated that R1 had been crying and wanting to go home several days prior to her leaving the facility on 10/3/14.

On 10/24/14 at 2:20 pm E6, Licensed Practical Nurse and R1's Primary Nurse stated that R1 was confused and had voiced to her family that she wanted to go home on multiple occasions. E6 stated R1 was started on an anti-depressant on 9/23/14 because of her depression. E6 stated that R1 had not complained of her shoulder hurting prior to leaving the facility on 10/03/14.

On 10/24/14 at 4:00 pm E9, Registered Nurse states she was one of two staff members dispatched to retrieve R1 in the community and bring her back to the facility on 10/3/14. E9 stated that when she arrived at Z1's house, R1 was there. E9 stated that R1 had on khaki pants and one of the knees was covered in grass stains. E9 stated she asked R1 if she had fallen and R1 replied that she had fallen because the wind had caught her. R1 then told E9 that a young lady with

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S9999	Continued From page 5 a small child had helped her up off the ground and had taken her home. E9 stated that when R1 was put in the car for transport back to the facility, R1 complained that her left shoulder was hurting. E9 stated she had no knowledge of R1 complaining of shoulder pain prior to 10/3/14. On 10/24/14 at 4:45 pm, E1 stated that in-services were done with the staff on the Door Alarm policy, but they had not been done monthly as stated in facility policy. (A)	S9999		

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The facility will ensure that the resident environment remains as free of accident hazards as is possible and each resident will receive adequate supervision and assistance devices to prevent accidents.

The facility IDT immediately reviewed the plan of care for R1 and elopement assessment to ensure that interventions were in place to reduce the potential for elopement. Revisions were made to her plan of care on 10/3/14.

Facility IDT reviewed all residents currently at high risk for elopement to ensure that appropriate interventions were in place to reduce the potential for elopements. Revisions were made to the plans of care as needed.

Education was provided by Administrator/designee to all staff members concerning the facility Door Alarm Policy on immediately on 10/3/14 through 10/7/14. E3 and E4 were given Re-educations on Door Alarm Policy. However, they both saw the consultant silence the alarm and therefore thought that she had followed the policy so there was no need for their follow up.

The facility immediately tested all Door Alarms to ensure they were in working order.

The facility sent out a letter to all consultants explaining the facility Door Alarm Policy and the need to ask facility staff for assistance on 10/10/14. The 2567 mentions E5 as an Employee of Mattoon Rehabilitation and Health Care Center but she is not an employee, only a consultant for the facility. She was educated upon her commitment to this facility on our Door Alarm Policy and Procedures and noted that she failed to follow the policy.

The facility held a family meeting and sent out a letter to family members explaining the Door Alarm Policy and the need to ask for staff assistance on 10/8/14.

The facility will conduct random door alarm drills on all shifts and educate employees as needed.

The facility opened an Action Plan for the Door Alarms through our Quality Assurance Program to monitor for compliance.

Date of Completion: October 29,2014 accepted

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LONG TERM CARE
QUALITY ASSURANCE