

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145480	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/13/2024
NAME OF PROVIDER OR SUPPLIER  Mattoon Rehab & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE  2121 South Ninth Mattoon, IL 61938	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>42702</p> <p>Based on interview and record review the facility failed ensure for resident rights regarding personal property for one (R1) of three residents reviewed from a sample list of 12.</p> <p>Findings include:</p> <p>The facility provided Abuse Prevention and Prohibition Policy, revised date 1/2024 documents that residents have a right to personal property in the facility.</p> <p>The facility provided Resident's Rights for People in Long Term Care Facilities, revised date 3/2017, documents that resident's have a right to privacy.</p> <p>The facility provided grievance dated 5/3/24 documents that R2 complained that V11 CNA was going through R1's drawers when he thought that they were both asleep.</p> <p>On 5/8/24 at 10:30AM, R1 stated, (V11 CNA) went through my drawers and I don't like that.</p> <p>On 5/8/24 at 10:45AM, R2 stated, I caught that guy going through her drawers when he thought that we were asleep. We don't want him in here anymore, going through our drawers. He said he was getting washcloths.</p> <p>On 5/9/24 at 3:33PM, V11 CNA said that he did open R1's drawers to get the rags out and that he didn't ask her if it was ok to do so.</p> <p>On 5/8/24 at 1:00PM, V2 Director of Nursing said that R2 filled out a grievance because she found V11 CNA going through her roommates drawers. We found that he was removing washcloths that he had placed there but decided just to keep him out of that room to prevent any further issues.</p> <p>On 5/13/24 at 11:00AM, V18 Assistant Director of Nursing stated, They should always ask before opening a resident's drawers. On 5/13/24 at 11:05AM, V29 Regional Clinical Director of Operations stated, I agree with that. They should always ask first.</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41970</p> <p>Based on interview and record review the facility failed to protect resident's rights to be free from physical abuse by another resident. This failure affects five (R3, R4, R5, R6, R7) residents of 12 residents reviewed for abuse in a sample list of 12 residents.</p> <p>Findings include:</p> <p>The facility policy titled 'Abuse, Prevention and Prohibition Policy' revised January 2024 documents each resident has the right to be free from abuse, corporal punishment and involuntary seclusion. The facility prohibits mistreatment, neglect and abuse of residents. The facility Administrator will be designated as the Abuse Coordinator. If the Administrator is not available to address this role then the Administrator will designate a 'person in charge' in their absence to fulfill the role. The Administrator will ensure a thorough investigation of alleged violations of individual rights and document appropriate action. A licensed professional nurse will assess the resident for signs of injury and notify the resident's physician and responsible party if any injury occurred. Resident to resident abuse includes the term willful. The term 'willful' means that the individuals actions were deliberate (not inadvertent or accidental), regardless of whether the individual intended to inflict injury or harm. Physical Abuse includes but is not limited to hitting, slapping, punching, biting and kicking.</p> <p>R3's Minimum Data Set (MDS) dated [DATE] documents R3 as cognitively intact. This same MDS documents R3 requires maximum assist for bathing, dependent on staff for dressing and supervision with eating, toileting and personal hygiene. R3's Electronic Medical Record does not include an Abuse Risk Assessment. This same EMR documents R3 propels independently in wheelchair. R3's Behavior Tracking sheet dated April and May 2024 documents R3 had 'hitting' behaviors on 4/16/24, 4/27/24 and 5/3/24. On 5/8/24 at 2:52 PM R3 stated I get mad at them (other residents). They get in my way. I don't like that. When I get mad I yell. Sometimes I hit them. They are in my way. That is not nice. They are in my way.</p> <p>1.) R7's undated Medical Diagnosis List includes medical diagnoses of Metabolic Encephalopathy, Acute and Chronic Respiratory Failure with Hypoxia and Hypercapnia, Scapholunte Dissociation of Radialcarpal joint of Left Wrist, Nephrogenic Diabetes Insipidus, Diabetes Mellitus Type II, Moderate Intellectual Disability, Schizophrenia, Chronic Obstructive Pulmonary Disease, Hearing Loss, Abnormalities of Gait and Mobility, and Muscle Weakness.</p> <p>R7's Minimum Data Set (MDS) dated [DATE] documents R7 as cognitively intact. This same MDS documents R7 as requiring moderate staff assistance with mobility and transfers.</p> <p>R7's Care Plan initiated 3/6/2024 does not include a focus area, goal nor interventions for R7 being at risk of abuse. R7's Electronic Medical Record (EMR) does not document an Abuse Risk Assessment nor a skin evaluation on 5/5/24.</p> <p>On 5/8/24 at 2:30 PM R7 wearing splint on Left Hand covering Left hand and lower wrist area (medical).</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/9/24 at 4:00 PM R7 stated (R3) was trying to steal a personal item from the seat of R7's wheelchair while R7 was sitting in it. R7 keeps a personal item next to her in the seat of her wheelchair, and takes it everywhere. R7 stated (R3) came up to me and tried to steal (personal item). That really upset me. I was trying to push (R3) away and he grabbed my wrist and then punched me in the arm. (R7 using her Left hand to show where R3 hit her on her Right wrist and lower forearm). R7 was wearing a splint on her Left Hand/Wrist. R7 stated You can see I can't do anything with my Left Hand. I couldn't have hit him back or anything. R7 further stated, (R3) just kept trying to get R7's (personal item) even when the staff were telling him (R3) to stop it.</p> <p>2.) R5's undated Medical Diagnosis List documents R5's medical diagnoses as Cognitive Communication Deficit, Paroxysmal Atrial Fibrillation, Muscle Weakness, Reduced Mobility, Dementia, Weakness, Spinal Stenosis and Raynaud's Syndrome.</p> <p>R5's Minimum Data Set (MDS) dated [DATE] documents R5 as cognitively intact. This same MDS documents R5 requires maximum staff assistance with mobility and transfers.</p> <p>R5's Care Plan initiated 10/8/2019 does not include a focus area, goal nor interventions for R5 being at risk of abuse. R5's Electronic Medical Record (EMR) does not document an Abuse Risk Assessment.</p> <p>R5's Skin Evaluation dated 5/5/24 documents R5 was struck in the Right Deltoid by another resident (R3) with no bruising or skin impairment noted.</p> <p>On 5/9/24 at 3:45 PM R5 stated (R3) is a bully. (R3) hits on people. I have seen (R3) do that before. I was minding my own business and that nurse (V7) drove (R3) right by me and (R3) punched me in my Right arm. (R5 rubbing her upper Right arm just below shoulder). (V7) could have driven (R3) a different direction. There were a lot of residents sitting in the hallway waiting to be driven down to breakfast. (V7) drove (R3) right by those and then (R3) punched me. It hurt but didn't break my arm or anything. I am tough.</p> <p>On 5/9/24 at 3:50 PM V25 (R5's) family member stated (V7) Licensed Practical Nurse (LPN) called me that morning (5/5/) to let me know (R3) punched (R5) in the arm. (V7) LPN told me the whole story. (V7) told me that (R3) was agitated and had been removed from the area of another resident (R7). I don't know why (V7) would wheel (R3) right next to other residents. I like (V7) LPN but that was not a good idea. It put (R5) and the other residents who got hit in danger.</p> <p>3.) R6's undated Medical Diagnosis List documents R6's medical diagnoses as Cognitive Social or Emotional Deficit Following other Cerebrovascular Disease, Hydrocephalus, Difficulty in Walking, Weakness, Reduced Mobility and Dementia with Agitation.</p> <p>R6's Minimum Data Set (MDS) dated [DATE] documents R6 as severely cognitively impaired. This same MDS documents R6 as being dependent on staff for mobility and transfers.</p> <p>R6's Care Plan initiated 5/10/2021 does not include a focus area, goal nor interventions for R6 being at risk of abuse. R6's Electronic Medical Record (EMR) does not document an Abuse Risk Assessment.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R6's Skin Evaluation dated 5/5/24 documents R6 was struck in the Right Deltoid by another resident (R3) with no bruising or skin impairment noted.</p> <p>On 5/9/24 at 1:55 PM R6 was laying in his bed watching television. R6 stated I was on my way down this hall (200 hall) to get something to eat when that nurse (V7) Licensed Practical Nurse (LPN) pushed (R3) right by me. (R3) just reached out his arm and punched me right in the arm. I was going to punch him back to (V7) had already taken (R3) away by then. That hurt but not bad. I would have hurt him (R3) worse. That son of a b**** (expletive) can't just go around hitting people. Right before (R3) hit me, he hit some other old lady in a wheelchair (R5). Now what kind of a***** (expletive) hits old ladies in wheelchairs? I hope they (facility) lock him (R3) away somewhere.</p> <p>On 5/9/24 at 1:50 PM V21 Certified Nurse Aide (CNA) stated V21 witnessed R3 grab at R7's (personal item) as R7 was sitting in the 200 hall. V21 stated This all happened right before breakfast on 5/5/24. (R3) was trying to grab (R7's) (personal item). (R3) got upset and started playing too rough trying to get (R7's) (personal item) and (R7) didn't like that. (R7) was yelling out 'stop that'. (V7) Licensed Practical Nurse (LPN) and I walked up to (R3) and (R7). (V7) LPN took (R3) away from (R7). (V7) then wheeled (R3) down the hall to his room but (V7) wheeled (R3) right by them (R5, R6). (R3) then reached out and punched (R5) in the upper arm. (R5) yelled out and said 'ouch! That hurt!'. (V7) kept pushing (R3) in his wheelchair to (R3's) room but then after (R3) hit (R5), (R3) punched (R6) in the arm. There was 10-15 feet between residents. I don't know why (V7) LPN kept pushing (R3) right by them (R5, R6). Looking back, we (V7, V21) should have moved those other residents out of the way so they wouldn't have been punched like that.</p> <p>On 5/9/24 at 3:00 PM V7 Licensed Practical Nurse (LPN) stated V7 was the nurse for R3, R5, R6 and R7 on 5/5/24. V7 LPN stated I was passing medications on the 200 hall before breakfast on 5/5/24. Those residents (R3, R5, R6, R7) all live on the same hall. I had just given (R3) his medications and (R3) pushed himself out of his room. The next thing I know is that I heard yelling from around the nurses station. (R3) was trying to take (R7's) (personal item) away from her. (R7) was yelling out because she was trying to get our attention to get (R3) away from her. I went over there and removed (R3) from (R7). I said 'Hey (R3) what are you doing?'. The hallway was full of residents in wheelchairs waiting to be taken to the dining room for breakfast. I pushed (R3) in his wheelchair down the hall in front of numerous residents. (R3) then all of a sudden reached out and punched (R5) in the Right Deltoid. It just came out of nowhere. So I continued pushing (R3) down the hall trying to get (R3) to his room and we passed another resident (R6). Then (R3) suddenly reached out and punched (R6) in the Right Deltoid too. There was a Certified Nurse Aide (CNA) (V21) there at the same time. I was just trying to get (R3) down to his room. I had no choice but to wheel him right in front of all of those other residents. They (other residents) didn't need to be removed. They were just innocently sitting there.</p> <p>On 5/9/24 at 3:20 PM V2 Director of Nurses (DON) stated R3 attempted to take R7's (personal item) away from R7 and became agitated when R7 would not let R3 have the (personal item). V2 DON stated V7 LPN attempted to remove R3 from the area by wheeling R3 down the hall directly in front of other residents. V2 DON stated R3 subsequently ended up punching two other residents (R5, R6) as V7 LPN was wheeling R3 by them (R5, R6). V2 DON stated V7 LPN should have removed the other residents (R5, R6) from the area before assisting R3 through the hall, called on help from other staff to assist with providing a clear path and/or taken R3 to another private area so as to not provide direct access for R3 to injure anyone else. V2 DON stated R5 and R6 were placed directly in the path of a resident (R3) who was having behaviors which put R5 and R6 at a risk of being hit also.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4.) R4's Minimum Data Set (MDS) dated [DATE] documents R4 as severely cognitively impaired This same MDS documents R4 requires moderate assistance for mobility and transfers.</p> <p>R4's Care Plan dated 8/23/23 does not include a focus area, goal nor intervention for R4 being at risk for abuse. R4's Electronic Medical Record (EMR) does not include an Abuse Risk Assessment.</p> <p>R4's Final Incident Report to State Agency dated 4/23/24 documents On 4/16/23 staff witnessed (R3) and (R4) have a physical altercation with each other while trying to exit the dining room. (V4) Certified Nurse Aide (CNA) reports that he observed (R3) pushing his wheelchair backwards towards the table (R4) was sitting at. (V4) stated he attempted redirection with (R3) however (R3) continued to back his wheelchair into the table where (R4) was sitting at. (R4) pushed (R3's) arm to get (R3) away and then (R3) hit (R4). (V5) Certified Nurse Aide (CNA) stated she did not see (R3) backing into (R4's) table but witnessed (R3) hit (R4). This same report documents R4 stated (R4) stated 'all of a sudden tried to beat me up but I took care of them and it's over now. It is the guy (R3) who causes problems, but we have an understanding now.</p> <p>On 5/9/24 at 3:15 PM V2 Director of Nurses stated R3 hit R4 in the dining room on 4/16/23. V2 DON stated R4 was sitting at his own dining room table and R3 was trying to push through the tables to leave the dining room. V2 stated R4 pushed R3's arm off of R4's wheelchair and then R3 got mad and hit R4 in the arm. V2 stated staff should have redirected and/or assisted R3 away from R4's table. V2 DON stated this incident occurred in the dining room with 'plenty of staff available to intervene'. V2 DON stated this incident could have been avoided all together if staff would have assisted R3 out of the dining room.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>42702</p> <p>Based on interview and record review the facility failed to implement their abuse policy for one (R1) of twelve residents reviewed for abuse from a total sample list of 12.</p> <p>Findings include:</p> <p>The facility abuse policy revised date 1/2024 documents that each resident has the right to be free from abuse and that the facility's abuse prohibition program includes screening, training, prevention, identification, investigation, protection and reporting/response. Resident abuse must be reported immediately to the Administrator. The facility Administrator will ensure a thorough investigation of alleged violation of individual rights and document appropriate action. While a facility investigation is under way, steps will be taken to prevent further abuse. If a person is identified in thru allegation of abuse, that person will not be allowed access to the facility while the investigation is in progress except to meet with the administrator as apart of the investgation. The person identified in the allegation of abuse will have no contact with resident or other employees during the investigation process.</p> <p>On 5/8/23 at 1:17PM, V17 LPN local physician's office said that on Monday, May 6, 2024, R1 told her that there was an employee at the facility where she lived (V11 CNA) that made her feel unsafe and that V17 LPN reported this to the facility immediately after the appointment.</p> <p>On 5/8/24 at 1:10PM, V1 Administrator said that after V17 LPN from the local physicians office called, she spoke to R1 and decided that no abuse had occurred, so she didn't investigate it or report it.</p> <p>The nursing schedule dated 5/7/24 documents that V11 Certified Nursing Assistant worked from 2:00PM to 6:00AM on 5/8/24.</p> <p>On 5/8/24 at 10:30AM, R1 stated, (V11 CNA) worked last night.</p> <p>On 5/9/24 at 10:00AM, V17 Regional Clinical Nurse said that V11 CNA had been suspended pending investigation.</p> <p>On 5/13/24 at 2:10PM, V29 Regional Director of Operations said that any time abuse is alleged, the facility policy says to investigate and report the allegation and the policy was not followed in this case.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>42702</p> <p>Based on interview and record review the facility failed to report allegations of physical and potential sexual abuse timely to the State Agency for three (R1, R6, and R7) of 12 residents reviewed for abuse from a total sample list of 12 residents.</p> <p>Findings include:</p> <p>The facility policy titled 'Abuse, Prevention and Prohibition Policy' revised January 2024 documents each resident has the right to be free from abuse, corporal punishment and involuntary seclusion. The facility prohibits mistreatment, neglect and abuse of residents. The facility Administrator will be designated as the Abuse Coordinator. If the Administrator is not available to address this role then the Administrator will designate a 'person in charge' in their absence to fulfill the role. The Administrator will ensure a thorough investigation of alleged violations of individual rights and document appropriate action. Initiate an investigation including initial reporting to all required agencies. The facility Administrator or designee who is made aware of any allegation of abuse or neglect shall report to the State Agency. The Administrator will report the allegation of abuse and neglect to the mandated State Agency and law enforcement. The allegation will be reported no later than two hours, or per state regulations, after the allegation is made.</p> <p>1.) On 5/8/23 at 1:17PM, V17 LPN Local Physician's Office said that she has to ask all patients about feeling safe in their homes. When I asked R1 about this, R1 told me that there was a male CNA at the nursing facility where she was living who might have had an erection when he was giving her a shower and that he went through her drawers and she felt like he was going to steal from her. I reported this to (V2 DON) at the facility immediately after the appointment.</p> <p>On 5/8/24 at 1:10PM, V1 Administrator stated, V17 LPN at Local Physician's office called both myself and V2 DON. She got through to V2 DON first and she had her on speaker phone telling her that R1 had complained at her appointment about about V11 CNA because he was watching her in the shower and that she might have felt an erection on her shoulder. (V11 CNA) was already not allowed to go into R1's room anymore because of her roommate's grievance. I didn't think that it wasn't abuse and I didn't report it.</p> <p>On 5/8/24 at 1:20PM, V2 Director of Nursing stated, When V1 Administrator and I became aware of what R1 said, V1 said that she was going to talk to R1, but I never heard anything more about it. V1 is our abuse coordinator.</p> <p>During this survey the facility was unable to provide documentation of the above incident, an investigation of the incident, or a report to the state agency.</p> <p>On 5/9/24 at 9:00AM, V29 Regional Director of Operations said that the incident had been reported both to the state agency and the police and the investigation had begun as of 5/8/24.</p> <p>On 5/8/24 at 2:20PM, V19 Regional Clinical Nurse said that based on the facility policy, the allegation of abuse should have been reported and an investigation begun immediately.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970</b></p> <p>Based on interview and record review the facility failed to protect residents from physical abuse from another resident with known physical aggression, failed to investigate resident allegations of abuse by another resident and allegation of potential abuse by staff. These failures affect five (R5, R6, R7, R3, R1) residents out of 12 residents reviewed for abuse in a sample list of 12 residents.</p> <p>Findings include:</p> <p>The facility policy titled 'Abuse, Prevention and Prohibition Policy' revised January 2024 documents each resident has the right to be free from abuse, corporal punishment and involuntary seclusion. The facility prohibits mistreatment, neglect and abuse of residents. The facility Administrator will be designated as the Abuse Coordinator. If the Administrator is not available to address this role then the Administrator will designate a 'person in charge' in their absence to fulfill the role. The Administrator will ensure a thorough investigation of alleged violations of individual rights and document appropriate action. While a facility investigation is underway, steps will be taken to prevent further abuse. Initiate an investigation including initial reporting to all required agencies.</p> <p>Complete a thorough investigation. Two management level staff will conduct interviews with witnesses or other staff, residents or visitors who could have knowledge of the allegation. Witnesses will be asked to assist in completing statements if indicated. When another resident is the alleged perpetrator of the abuse, a licensed professional shall immediately evaluate the resident's physical and mental status, care plan, monitor behaviors and notify the physician for a determination regarding treatment and/or discharge options. Residents will be referred to behavior management when indicated.</p> <p>The Final Incident Report to the State Agency dated 5/10/2024 documents R3 had become agitated when R3 attempted to take R7's (personal item) from R7. R21 Certified Nurse Aide (CNA) Witness Statement dated 5/5/24 at 7:30 AM documents R3 grabbed R7's hand and wrist. This report documents V7 Licensed Practical Nurse (LPN) then assisted R3 in his wheelchair past R5 and R6 where R3 punched R5 and then R6 both in the Right Deltoid. This same report documents Based on staff and resident interviews, the altercations did occur.</p> <p>1.) R5's Minimum Data Set (MDS) dated [DATE] documents R5 as cognitively intact. This same MDS documents R5 requires supervision with toileting, personal hygiene, bathing, maximum assistance with dressing and transfers. On 5/9/24 at 3:45 PM R5 stated I was minding my own business and that nurse (V7) drove (R3) right by me and (R3) punched me in my Right arm. (R5 rubbing her upper Right arm just below shoulder). (V7) could have driven (R3) a different direction.</p> <p>On 5/9/24 at 3:50 PM V25 (R5's) family member stated (V7) Licensed Practical Nurse (LPN) told me that (R3) was agitated and had been removed from the area of another resident (R7). I don't know why (V7) would wheel (R3) right next to other residents, it put (R5) and the other residents who got hit in danger.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145480	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/13/2024
NAME OF PROVIDER OR SUPPLIER  Mattoon Rehab & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE  2121 South Ninth Mattoon, IL 61938	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. R6's Minimum Data Set (MDS) dated [DATE] documents R6 as severely cognitively impaired. This same MDS documents R6 as requiring maximum assistance for bathing, dressing and is dependent on staff for transfers and toileting. On 5/9/24 at 1:55 PM R6 stated I was on my way down this hall (200 hall) to get something to eat when that nurse (V7) pushed (R3) right by me. (R3) just reached out his arm and punched me right in the arm.</p> <p>On 5/9/24 at 3:20 PM V2 Director of Nurses (DON) stated R3 attempted to take R7's (personal item) away from R7 and became agitated when R7 would not let R3 have the (personal item). V2 DON stated V7 LPN attempted to remove R3 from the area by wheeling R3 down the hall directly in front of other residents. V2 DON stated R3 subsequently ended up punching two other residents (R5, R6) as V7 LPN was wheeling R3 by them (R5, R6). V2 DON stated V7 LPN should have removed the other residents (R5, R6) from the area before assisting R3 through the hall, called on help from other staff to assist with providing a clear path and/or taken R3 to another private area so as to not provide direct access for R3 to injure anyone else. V2 DON stated R5 and R6 were placed directly in the path of a resident (R3) who was having behaviors which put R5 and R6 at a risk of being hit also.</p> <p>3.) R7's Minimum Data Set (MDS) dated [DATE] documents R7 as cognitively intact. This same MDS documents R7 as requiring moderate staff assistance with mobility and transfers. On 5/9/24 at 4:00 PM R7 stated (R3) was trying to steal my (personal item). (R3) came up to me and tried to steal (personal item). I was trying to push (R3) away and he grabbed my wrist and then punched me in the arm. (R5 using her Left hand to show where R3 hit her on her Right wrist and lower forearm).</p> <p>On 5/9/24 at 3:30 PM V2 Director of Nurses (DON) stated the staff responded quickly to the physical altercation between R3 and R7 on the morning of 5/5/24. V2 DON stated after that physical altercation, the staff completed hand written interviews which included V21 Certified Nurse Aide (CNA) written witness statement. V2 DON stated V21's written statement documented R7's allegation of physical abuse from R3. V2 DON stated the allegation of physical abuse should have been investigated, the residents (R3, R7) both should have had physical assessments completed timely and R3 should have been kept away from other residents until the investigation was completed.</p> <p>42702</p> <p>4.) R1's Minimum data set dated [DATE] documents R1 as cognitively intact and requiring clean up assistance with toileting and partial to moderate assistance with bathing.</p> <p>On 5/8/23 at 1:17PM, V17 Licensed Practical Nurse (LPN) at a local physician's office said that she has to ask all patients about feeling safe in their homes. When I asked R1 about this on Monday, (May 6, 2024), R1 told me that there was a male CNA at the nursing facility where she was living who might have had an erection when he was giving her a shower and that he went through her drawers and she felt like he was going to steal from her. I reported this to (V2 DON) at the facility immediately after the appointment.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Mattoon Rehab & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE  2121 South Ninth Mattoon, IL 61938	

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/8/24 at 1:10PM, V1 Administrator said that V17 LPN at a local physician's office called both myself and V2 DON on May 6, 2024. She got through to V2 DON first and while she had her on speaker phone, I heard her telling V2 DON that R1 had complained at her appointment about about V11 CNA because he was watching her in the shower and that she might have felt an erection on her shoulder. (V11 CNA) was already not allowed to go into R1's room anymore because of her roommate's grievance. I didn't think that it wasn't abuse and I didn't report it. I felt after talking to her that there was no need to investigate further.</p> <p>The facility could not provide documentation of an investigation of the above abuse allegation.</p> <p>On 5/8/24 at 2:20PM, V19 Regional Clinical Nurse said that based on the facility policy, this should have been investigated completely.</p> <p>On 5/9/24 at 9:00AM, V29 Regional Director of Operations said the full investigation was not started until 5/8/24.</p>