STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145480	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mattoon Rehab & Hcc	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)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 31642 Based on observation, interview, and record review, the facility failed to revise a resident's care plan to reflect the actual health status after a change in residents condition. This failure affects one resident (R1) out of three residents reviewed for care plans on the sample list of 7. Findings include: R1's Diagnoses Sheet updated 5/14/24 documents R1's Primary, Admission Diagnosis for Medical Management was Alcohol Abuse, Uncomplicated. R1's Care Plan updated 7/23/24 with the following interventions: (R1) is at risk for falls. Educate family to provide assistance with transfers and ambulation when out in the community. This same plan of care does not include any mention of the primary diagnosis of medical management Alcohol Abuse, Uncomplicated, or interventions to prevent future exacerbation. R1's SBAR (Situation, Background,Assessment, and Recommendation) note dated 7/22/2024 at 1:09 pm documents the following:Note Text: The resident is experiencing a change in condition. See SBAR assessment for further information and family/physician notification. The change in condition the resident is currently experiencing is resident returned from being out in the community with the smell of ETOH (alcohol) and belligerent language. R1's Health Status Note dated 7/22/2024 at 2:00 pm documents the following: Note Text: (continued on next page)

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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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident returned around 12:45 pm from being out in the community w/his female significant other. Resident was being loud in the hallway. Resident smelled of ETOH (Primary diagnoses on 5/14/24 diagnosis documented above) . (R1's treatment plan for alcohol dependency was not entered on R1's care plan or interventions to prevent complications). Resident was slurring his words and being uncooperative. The DON (V6, previous Director of Nursing) and this nurse (V12, Licensed Practical Nurse) went to interview resident. Resident denied use of alcohol or drugs while he was out. (V11, Physician) was notified at 13:05 (1:05 pm) that resident returned with the smell of ETOH. NOR (new orders received) to send resident to (local hospital) ED (hospital, emergency department) for eval (evaluation) & treatment for ETOH & drug screening. Resident was in the hallway being belligerent & yelling profanities. Resident brought up to the nurses station and placed in another room away from his roommate, whom he was belittling and being verbally inappropriate. EMS (Emergency Medical Service) arrived at approximately 1320 (1:20 pm) w/1 (with one) police officer present. Resident was uncooperative, belligerent & verbally inappropriate to EMS & the police officer. At approximately 1340 (1:40 pm), 3 (three) more police officers showed up to the facility. The police officers took resident and placed him on the EMS stretcher. Resident was taken from the facility via stretcher and EMS to (local hospital) ED at approximately 13:55 (1:55 pm). Attempted several times to speak to someone at the ED, but was unable to speak to anyone. R1's Social Service Note dated 7/23/2024 at 1:50 pm documents: Late Entry: Note Text: Meeting (care plan meeting, not updated to guide all staff in prevention) held with (R1). He states that he is sorry for his actions the day before and that he will not do them again that he made a stupid decision. He also states that he is fine with getting education from AA (Alcoholics Anonymous). He is also open to getting information in regard to other facilities that would be able to manage his alcoholism. At present he would like to stay in the facility, but he understands that the facility has to make sure that everyone remains safe. (R1) states that he has a sponsor (proper first name) and that the facility can reach out to him. He gave SSD (V17, Social Service Director) his (sponsors) number. R1 SBAR dated 8/6/2024 (two weeks after the above documented ETOH intoxication and transport to the hospital) at 2:15 pm documents a second event related to R1's intoxication. Note Text: The resident is experiencing a change in condition. See SBAR assessment for further information and family/physician notification. The change in condition the resident is currently experiencing is ETOH intoxication, belligerence, uncooperative. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Health Status Note dated 8/6/2024 at 4:15 pm documents in detail the SBAR identified above information: Note Text: This writer noticed a change in resident's behavior. Resident began playing his music loud, being overly verbally affectionate to staff (unidentified). Resident then decided to ambulate w (with)/ his walker. PTA (V19, Physical Therapy Assistant) quickly came to assist resident w/ambulation, trying to get him to stop and sit in his wheelchair. Resident became belligerent, uncooperative, argumentative w/staff/therapy. Staff found 1 (one) empty bottle of Vodka and an open bottle of Vodka. Resident denied drinking or taking anything. MD (V11, Physician) notified. NOR to send resident to ED for eval (evaluation). EMS notified and arrived to facility. EMS departed facility R/T (related to) resident was A/Ox4 (alert and oriented to person,place,time and event) and refused to go to the ED. (local) PD (police department) notified and arrived to facility. PD unable to assist in removal of resident. Resident became belligerent w/PD. Resident agreed to a breathalyzer, then refused because PD wouldn't take him out of the facility. Resident requested to take his alcohol w/ him if the PD would take him. PD informed him that was not an option. (local) PD departed the facility. Resident then requested to d/c from the facility. MD notified and NOR to d/c. No one was available to come get him. Psych (Psychiatric) NP (V13, Nurse Practitioner) gave the order for a 72 hour psych hold (involuntary hospital admission documented below) at (local hospital). EMS arrived and transported resident to (local hospital) ED. The facility Inpatient (hospitalization) Certificate dated 8/6/24, regarding R1, documents the following: Based on the foregoing examination it is my opinion that he or she is: A person with mental illness who, because of his or her illness is reasonably expected, unless treated on an inpatient basis, to engage in conduct placing such person or another in physical harm or in reasonable expectation of being physically harmed; I (signed by V13, Psychiatric Nurse Practitioner) believe that the individual is subject to: (second box marked on form) Involuntary inpatient admission and is in need of immediate hospitalization . On 8/15/24 at 3:00 pm V17, Social Service Director (SSD) stated R1 had a care plan meeting 7/23/24 after his hospital emergency room visit 7/22/24 for ETOH intoxication. V17 stated V17 does not know why the intervention to refrain from going out on pass, and R1 committed to is not on the care plan. V17 said V17 does not know why ETOH is not on R1's 'care plan at all'. On 8/15/24 at 3:05 pm V3, Registered Nurse/ Minimum Data Set/Care Plan Coordinator stated I was not told to update (R1) care plan related to ETOH problem. I would have, had I known. On 8/15/24 at 3:10 pm V2, Regional Nurse reviewed R1's Care Plan and stated V17, SSD, V6, Previous Director of Nursing and V2 were in the care plan meeting 7/23/24 with R1. ETOH was a problem that should have been on the care plan. The facility policy Care Planning - Interdisciplinary Team ' dated January 2017 documents the following: Policy: Every resident will be assessed using the Minimum Data Set (MDS) according to the guidelines set forth in the Resident Assessment Instrument (RAI) manual. Purpose: 1) To assess each resident's strengths, weaknesses, and care needs (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) To use this assessment data to develop a comprehensive Plan of Care (POC) for each resident that will assist a resident in achieving and maintaining the highest practical level of mental functioning, physical functioning, and well being as possible. 3) To enter this assessment data into a computerized format that will be transmitted to the Center for Medicare/Medicaid Services (CMS). The same care plan policy documents: 1) Upon completion of comprehensive assessments (as defined by the RAI Manual), CAAs (Care Area Assessment) will be triggered to flag areas of concern that may need to be addressed in the POC (plan of care) for that resident. Each triggered CAA will be reviewed by designated staff to determine if a triggered condition affects the resident's function and quality of life or if the resident is at significant risk of developing the triggered condition. 2) CAA documentation will be done following guidelines in the RAI Manual and will state whether or not a care plan is needed to address the triggered area and the rationale for arriving at this decision. 3) While CAA's identify common areas of concern in nursing home residents, the POC is not to be limited to the triggered areas. The comprehensive POC must address all care issues that are relevant to the individual, whether or not they are specifically covered in the MDS/CAA process.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 31642 Based on observation, interview, and record review the facility failed to employ the services of a full-time Director of Nursing. This failure has the potential to affect all 90 residents residing in the facility. Findings include: On 08/14/24 at 9:05 there was no Director of Nursing (DON) present in the building to complete entrance paperwork. On 8/14/24 at 9:10 am V3, Registered Nurse/ Minimum Data Set/Care Plan Coordinator stated the facility does not have a full-time Director of Nursing. On 8/14/24 at 9:25 am V2, Regional Nurse completed the entrance paperwork for this survey. V2 stated V2 is not full time in the facility. V2 works in this facility on average two days a week, to help the facility in the absence of a full-time DON. On 8/15/24 at 11:45 am V6, Previous DON stated her last day working in the facility was 7/31/24. The facility 802 Matrix dated 8/14/24 document 90 residents are currently residing in the facility.