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	10/25/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32172 Based on interview and record review the facility failed to protect the residents' right to be free from verbal abuse by another resident and mental abuse by a staff member. This failure affected three of four residents (R1, R3, R4) reviewed for abuse in the sample of four. Findings Include: The facility's Abuse Prevention Program dated October 2022 documents the facility affirms the right of it's residents to be free from abuse or mistreatment. Abuse means the willful infliction of injury, intimidation or punishment resulting in physical harm, pain, or mental anguish. Verbal abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of an individuals' age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, threats of harm or saying things to frighten a resident. Mental abuse includes but is not limited to threats of punishment or deprivation. 1. The Abuse Investigation Summary dated 10/9/24 documents R1 reported V7 Certified Nurses Assistant (CNA) made statements to R1 that were inappropriate and threatening in tone. V9 Admissions' statement dated 10/9/24 documents R1's Wife (V17) reported to her that V7 CNA told R1 that if he didn't stop putting on his call light she was going to beat him. R1's Medical Diagnoses sheet dated October 2024 documents R1 is diagnosed with Cerebral Infarction, Muscle Weakness, Difficulty Walking, and Spine Fusion. R1's Minimum Data Set (MDS) dated [DATE] documents R1 is cognitively intact. On 10/24/24 at 3:57 PM R1 stated on the night of 10/8/24 V7 CNA came into his room three times to answer his call light. V7 had an attitude that he continued to put on his call light when his needs were not being met by the nursing staff. R1 stated V7 CNA came into his room and told him if he did not stop putting on his call light, she would beat him half to death. V7 then left the room and did not return. R1 stated she had an attitude the entire shift but she should not be making threatening remarks to residents. R1 stated V7 CNA should not be in a caring profession if she cannot be professional or does not actually care about the residents. R1 stated he never wants V7 to care for him again. (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

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 10/25/2024
NAME OF PROVIDER OR SUPPLIER Mattoon Rehab & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE 2121 South Ninth Mattoon, IL 61938	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/25/24 at 2:00 PM V1 Administrator confirmed V7 CNA threatening R1 with physical violence if he did not quit using the call light is not acceptable behavior and is not the behavior the facility condones. V1 confirmed due to the allegation, V7 is no longer able to work at the facility. 2. The Abuse Investigation Summary dated 10/8/24 documents R3 and R4 were in a verbal altercation on 10/14/24. R3 stopped in the entrance to the dining room and refused to move when asked to by R4. R3 yelled and cursed at R4 and in return R4 cursed at R3. R3's Medical Diagnoses sheet dated October 2024 documents R3 is diagnosed with Depression. R3's Minimum Data Set (MDS) dated [DATE] documents R3 has a mild cognitive impairment. R3's Electronic Medical Record documents since June 2024 R3 has been involved in at least five verbal altercations with other residents. R3's Care Plan dated 10/22/24 documents R3 has a problem behavior of being verbally inappropriate with staff and residents. R4's Medical Diagnoses sheet dated October 2024 documents R4 is diagnosed with Depression and Anxiety. R4's Minimum Data Set (MDS) dated [DATE] documents R4 is cognitively intact. R4's Care Plan dated 5/12/24 documents R4 has a problem behavior of being verbally and physically aggressive with others. On 10/24/24 at 3:18 PM R4 stated when he tried to leave the dining room after the evening meal, R3 stopped in the doorway so he could not get through. He asked R3 to move and she refused. He asked R3 again and she yelled at him and told him to f*** (expletive) off. R4 stated that made him mad and he yelled and cursed back at her. R4 stated he has heard R3 yell and curse at other residents and he tries to avoid her if he can. On 10/25/24 at 1:40 PM V14 Social Services Director stated she was in her office when she heard residents yelling and cursing. V14 came out of her office and found R3 and R4 yelling at each other. R4 was trying to get past R3 who had stopped in the dining room doorway and R4 stated R3 had told him to f*** (expletive) off. R4 also admitted to cursing back at R3. V14 stated there were other residents in the area that could have heard the exchange between R3 and R4. V14 stated R3 has had multiple instances in the past with being verbally inappropriate/cursing at other residents. On 10/25/24 at 2:00 PM V1 Administrator confirmed the verbal altercation and use of expletives between R3 and R4 did occur and is not the behavior the facility condones.

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 32172

Based on interview and record review the facility failed to provide a safe transfer of a resident (R1) when assisting the resident to transfer into bed. This failure resulted in R1 sustaining a right shoulder dislocation which required overnight hospitalization and a surgical intervention. R1 is one of four residents reviewed for accidents on the sample list of four.

Findings Include:

The facility Incident Report Investigation dated 10/9/24 documents on the morning of 10/9/24 R2 complained of pain in her right shoulder and was sent to the emergency room for evaluation. R2 stated she believed the injury occurred when a staff member (V4 Certified Nurses Assistant) CNA from the evening prior transferred her into bed. R2 was found to have a right shoulder dislocation that required surgical intervention.

R2's Hospital Report dated 10/9/24 documents R2 presented to the emergency room with right shoulder pain and was found to have a right shoulder dislocation. R2 stated the pain began the night prior when staff moved her into the bed.

R2's Medical Diagnoses list dated October 2024 documents R2 is diagnosed with Muscle Weakness, Unsteadiness on Feet, Repeated Falls, Reduced Mobility, and Dislocation of Right Shoulder Joint.

R2's Minimum Data Set, dated dated dated [DATE] documents R2 has a mild cognitive impairment and requires substantial maximal assistance from staff for transfers.

R2's Transfer Status dated 10/1/24 documents R2 requires two staff persons for transfers and toileting.

On 10/24/24 at 3:28 PM R2 stated her right shoulder became dislocated a second time after V4 CNA transferred her into bed for the night. R1 stated V4 transferred her alone with no gait belt. R2 stated V4 must've pulled on her arm or moved it wrong. R2 stated her pain intensified over the next fifteen minutes and she was soon in extreme pain. R2 stated the pain continued into the morning. She was then transferred to the hospital and was diagnosed with a right shoulder dislocation which required surgical intervention.

On 10/25/24 at 10:19 AM V4 CNA stated she took care of R2 on the evening of 10/8/24. V4 stated she helped transfer R2 to and from the toilet and then also from the wheelchair to her bed for the night. V4 stated at the time of both transfers R2 did not have a sling on her right arm. V4 stated she was unsure if R2 was supposed to be wearing the sling but V4 denied clarifying to be sure. V4 stated she assisted R2 with no other help from staff and she did not use a gait belt during either transfer.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/25/24 at 11:35 AM V6 Registered Nurse stated she took care of R2 during the day on 10/8/24 and on 10/9/24. V6 stated when she came on shift at 6:00 AM on 10/9/24, R2 was in extreme pain. At about 6:30 AM, V6 assessed R2's right shoulder and it appeared out of place. R2 was sent to the emergency room for evaluation. V6 stated when she was assessing R2's pain/shoulder, R2 stated her shoulder started hurting after she was transferred into bed the night before. V6 stated the day prior (10/8/24) R2's shoulder was not in any pain. On 10/25/24 at 11:40 AM V13 Registered Nurse stated shortly after she came on shift at 10:00 PM on 10/8/24 R2 stated the staff who put her to bed had pulled on her right arm and it started hurting after that. R2 rated her pain as a 8/10 and requested Tramadol for pain, which was administered. V13 stated when she followed up with R2 a bit later, she was asleep. V13 stated at about 5:00 AM on 10/9/24 R2 woke up and was in extreme pain, again rating it as a 8/10. V13 again administered Tramadol. On 10/25/24 at 10:25 AM V8 Physical Therapist stated initially R2 was admitted for therapy after a fall at home which resulted in some foot fractures and a dislocation of her right shoulder. R2 had a sling on when she was admitted which she was to wear at all times. R2 was not allowed to use her shoulder or lift her arm at all. She should not have been transferring without her sling on or using her arm to stabilize herself at all. V4 CNA should have checked with nursing if she was not sure if R2's sling needed to be on or not. V4 should have used a gait belt when transferring R2. According to V8's assessment a week prior on 10/1/24 R2 required two staff for transfers in order to prevent falls/injury. V8 stated if R2 was not wearing the sling, used her arm in any way or V4 CNA pulled on her arm, even if by accident- it would have caused the re-dislocation to occur. On 10/25/24 at 2:00 PM V1 Administrator confirmed facility staff should ensure resident safety by following the plan of care for safe transfers in order to avoid injury.