

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 03/06/2025
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642</p> <p>Based on observation, interview and record review the facility failed to prevent cross contamination during wound treatments for one of three residents (R3) reviewed for infected wounds on the sample list of three.</p> <p>Findings include:</p> <p>R3's current Diagnoses sheet documents the following:) Lymphedema, Not Elsewhere Classified and Non-Pressure Chronic Ulcer of Unspecified Part Of Right Lower Leg With Unspecified Severity.</p> <p>R3's Minimum Data Set (MDS) dated [DATE] documents the following Brief Interview of Mental Status score of 15 out of 15, indicating no cognitive impairment. The same MDS documents R3 is at risk for pressure ulcers, and had two venous and arterial ulcers.</p> <p>R3's Physician Order Sheet (POS) dated 3/5/25 documents the following wound treatment orders: Wound Care: (L) calf: Cleanse w/ wound cleanser. Apply Santyl 250 UNIT/GM (gram)(Collagenase) ointment on wound bed followed by Calcium alginate (cut to fit) on wound bed. Cover with Superabsorbent dressing. Wrap with gauze wrap. Secure with tape. Change daily and PRN (as needed) soiling, slippage & unscheduled removal of dressing. Santyl External Ointment) and Wound Care: (R) Medial Malleolus: Cleanse with wound cleanser. Apply Santyl ointment on wound bed followed by Calcium alginate (cut to fit) on wound bed. Cover with Superabsorbent dressing. Wrap with gauze wrap. Secure with tape. Change daily & PRN soiling, slippage and unscheduled removal of dressing.</p> <p>The same POS documents the following antibiotic medication order:</p> <p>Meropenem Intravenous Solution Reconstituted 500 MG (milligrams). Use 500 mg intravenously two times a day for Multi-Organism Wound Infection (R) medial malleolus for 10 Days -Start Date- 02/21/2025.</p> <p>R3's Antimicrobial Stewardship: Molecular Lab Result Wound Culture collected 2/17/25 with results 2/19/25 documents the following bacteria are present but not quantified, in R3's right ankle wound, Wound Antibiotic Resistance</p> <p>Organism Detected:</p> <p>*Bacteroides fragilis</p> <p>(continued on next page)</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*Escherichia coli</p> <p>*Klebsiella pneumoniae</p> <p>*Proteus mirabilis</p> <p>*Pseudomonas aeruginosa</p> <p>*Staphylococcus aureus</p> <p>The same report documents:</p> <p>The detected organisms can be pathogenic when found in wound samples. Resistance genes were detected in multiple classes which may limit available treatment options.</p> <p>TMP-SMX</p> <p>Extended-Spectrum Beta-Lactamase Beta-lactam</p> <p>Tetracycline</p> <p>Antimicrobial Resistance High.</p> <p>On 3/6/25 at 10:35 am a sign was present on R3's door stating Enhanced Barrier Precaution/Contact Isolation See Nurse. PPE (personal protective equipment) supplies and hand sanitizer were present in the door caddy. V4, Wound Licensed Practical Nurse (LPN) and V11, LPN completed hand hygiene and donned gowns before they entered R3's room. V11, LPN had a draped, clean field set up with dressing supplies on R3's bedside table. R3 was lying in bed with the head of her bed slightly elevated. R3 had bilateral lower extremities compression stockings on. R3's right lower legs compression stocking had wet wound drainage at the right inner (medial) ankle joint bone (Malleolus) that had seeped through the gauze wrap covering R3's wound dressing. R3's left lower leg compression stocking had numerous dry, ring-shaped stains scattered on the front and back of the compression stocking covering R3's left posterior calf wound. V11, LPN acknowledge the compression stockings were soiled. V11 removed both of R3's compression stockings. V11, LPN placed a disposable linen savor under R3's bilateral lower legs. V11 removed her soiled gloves, repeated hand hygiene and donned new gloves. V11, LPN removed the clean scissors from the bedside table and cut off R3's soiled wet gauze wrap on the right lower leg, placing the scissors on the bedside table and next to the clean dressing supplies. V11 then removed a thick wet cotton dressing that overlaid R3's right Malleolus. V11 then removed beige wound drainage saturated calcium alginate from the wound bed. V11 disposed the soiled wound dressing items. V11, LPN removed her soiled gloves and went into the bathroom, washed her hands with soap and water and donned clean gloves. V11 cleansed R3's quarter sized open ankle wound with wound cleaner and four by four gauze and patted the area dry. V11 removed her soiled gloves, used hand sanitizer, donned new gloves.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>V11, LPN removed calcium alginate medicated pad and the soiled contaminated scissor from the bedside table. V11, LPN cut the calcium alginate pad to the wound bed size, using the same contaminated scissors she had cut the soiled gauze wrap off with. V11, LPN sat the soiled scissors on the bedside table. V11, LPN applied Santyl medicated ointment to the calcium alginate pad and placed it directly into R3's wound bed. V11 removed a Superabsorbent cotton dressing from the bedside table and covered the inner calcium alginate wound dressing. V11 applied moisturizer Ointment around the dressing and over R3's full right lower leg and foot. V11 then wrapped R3's lower right leg with gauze wrap and applied dated tape to secure. V11 removed and disposed of her gloves and returned to the bathroom and washed her hands. V11, LPN donned clean gloves and removed the same contaminated scissors off the bedside table. V11 cut off the gauze wrap dressing on R3's left lower leg. R3 had a four inch by four-inch dressing over the posterior aspect of her left calf. V11, LPN removed the soiled outer dressing and soiled calcium alginate from a quarter size left calf wound. There was scant serous drainage noted on the calcium alginate. V11, LPN removed the soiled gloves and went into the bathroom and washed her hands and donned new gloves.</p> <p>V4, Wound Nurse assisted R3 in holding her leg off the bed while V11 cleansed R3's left calf wound with wound cleanser and patted the area dry. V11 removed her soiled gloves, used hand sanitizer, donned new gloves. V11, LPN removed calcium alginate medicated pad and the soiled contaminated scissor from the bedside table. V11, LPN cut the calcium alginate pad to the wound bed size, using the same contaminated scissors. V11, LPN sat the soiled scissors on the bedside table. V11, LPN applied Santyl medicated ointment to the calcium alginate pad and placed it directly into R3's wound bed. V11 removed a Superabsorbent cotton dressing from the bedside table and covered the inner calcium alginate wound dressing. V11 applied moisturizer Ointment around the dressing and over R3's full left lower leg and foot. V11 then wrapped R3's lower right leg with gauze wraps and applied dated tape to secure. V11 removed and disposed of her gloves and returned to the bathroom and washed her hands after removing protective gown.</p> <p>On 3/6/25 at 11:05 am V11, LPN stated I thought about the scissors after the fact. I should have cleaned them with an alcohol wipe or bleach wipe after I cut off the (gauze wraps) and for sure before I cut the calcium alginate for both of those wounds.</p> <p>On 3/6/25 at 11:10 am V4, Wound Nurse stated I saw it too. The scissors should have been cleaned several times. (R3) just finished IV (intravenous) antibiotics for an infection in her right ankle wound.</p> <p>On 3/6/25 at 3:05 pm V2, Director of Nursing (DON) provided the facility policy Pressure Injury Assessment and Treatment Guideline - QA (Quality Assurance) Document dated January 2025. V2 stated the procedure in this policy V2 provided is the same for pressure ulcers as well and any wound treatment. Wound dressing needs to be cut to size using clean or sterile scissors to prevent cross-contamination, and the dressing should be dated and initialed by the nurse that completes the treatment. V2, DON stated We have bleach wipes in the building, those scissors used on (R3) treatment should have been cleaned each time they were contaminated.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642</p> <p>Based on observation, interview and record review the facility failed to complete physician ordered pressure ulcer treatments for one of three residents (R2) reviewed for infected wound/pressure ulcers on the sample list of three.</p> <p>Findings include:</p> <p>R2's current Diagnoses Sheet documents the following: Acquired Absence Of Left Leg, Above the Knee, Acquired Absence Of Right Leg, Below the Knee, Peripheral Vascular Disease, and Pressure Ulcer Of Sacral Region Stage IV.</p> <p>R2's Minimum Data Set (MDS) dated [DATE] documents the following: Brief Interview of Mental Status score of 15 out of a possible 15, indicating no cognitive impairment. The same MDS documents R2 has one Pressure Ulcer Stage III and one Pressure Ulcer Stage IV.</p> <p>R2's Physician Order Sheet (POS) dated 3/5/25 documents the following orders:</p> <p>Wound Care: (R) Trochanter wound (pressure ulcer Stage III): Cleanse with wound cleanser. Apply sureprep to periwound. Place Santyl in the wound bed. Loosely fill wound bed with Opticell gelling fiber. Cover with Superabsorbent dressing. Secure with bordered gauze. Change daily and PRN (as needed) soiling,</p> <p>Wound Care Coccyx wound (Pressure Ulcer Stage IV): Cleanse with wound cleanser. Apply sureprep to periwound. Place Santyl in the wound bed. Loosely fill wound bed with Opticell gelling fiber. Cover with Superabsorbent dressing. Secure with bordered gauze. Change daily and PRN soiling</p> <p>every day shift and as needed, and Refer resident (R2) to Infectious Disease and General Surgery for Osteomyelitis of right Trochanter and coccyx.</p> <p>R2's same POS documents the following antibiotic medication order: Amoxicillin-Pot Clavulanate Tablet 875-125 MG, Give 1 tablet by mouth every morning and at bedtime for wound infection for two Weeks -Start Date- 02/24/2025.</p> <p>R2's Hospital records dated 10/10/24 document an Magnetic Resonance Imaging (MRI) of the pelvis shows findings concerning for Osteomyelitis of the Greater Trochanter of the Right Femur and also of the Sacral Vertebral Body, The results were discussed with the nursing home staff. The patient will be offered referral to the wound clinic or to a general surgeon. He is seeing a wound provider (V8, Wound Nurse Practitioner) at the nursing home. He has completed a course of Meropenem (intravenous antibiotic medication). He does not have a Wound VAC in place.</p> <p>R2's Wound Specialist V8, Nurse Practitioner Progress Note dated 2/17/25 documents:</p> <p>Presence of bacteria (not specified) was identified No fluorescing was apparent on indicative of bacterial burden, in real-time visual wound imaging an excess of 10,000 Colony Forming</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Units per gram.</p> <p>R2's Treatment Administration Record dated 3/6/25 does not document a nurse's initials on 3/5/25, to indicate R2's Pressure Ulcer treatments were completed.</p> <p>On 3/6/25 at 2:20 pm an Enhanced Barrier Precaution/Contact Isolation See Nurse sign was on R2's door. Personal Protective Equipment supplies and hand sanitizer were present in the door caddy. V4, Wound LPN set-up a clean, draped field with R2's wound dressing supplies on a bedside table and placed it next to R2's bed. V4 used hand sanitizer and donned gloves and a gown and entered R2's room to complete R2's Pressure Ulcer Dressing changes. R2 was able to position himself using the left bedside rail to a partial left side side lying position. R2's Right Trochanter (hip region) was clearly visible. R2 had a heavily saturated bordered gauze dressing that was seeping beige drainage from the distal aspect of the right Trochanter Stage III Pressure ulcer wound dressing. R2's dressing was dated 3/4/25 and had V4's initials. V4 stated I guess nobody changed his dressings yesterday. I did it Tuesday (3/4/25) when I did rounds and measurement with (V8, Wound Nurse Practitioner). R2 then stated I waited and waited, expecting one of the nurses to come in and change these (pressure ulcer dressings) yesterday. I finally went to sleep and forgot all about it till this morning when you (surveyor) came in. V4, Wound LPN removed R2's right Trochanter bordered gauze dressing, absorbent pad and the wound bed strips. R2's right Trochanter was approximately a half dollar sized open wound. V4 removed and discarded the soiled dressings and then went into the bathroom and washed her hands with soap and water, donned new gloves and cleansed R2's right Trochanter Stage III pressure ulcer with four inch by four inch cotton pads and wound cleanser. V4 patted the areas dry, using a cotton tip to push the gauze under the edges of R2's Stage III wound. V4 stated R2 has undermining from three o'clock all the way around to nine o'clock. V4 removed gloves, washed hands in the bathroom and donned new gloves. V4 cut opti-gell fiber gelling material in a spiral like fashion, applied Santyl to the wound bed and inserted the spiraled material into the wound bed and tucked it below the undermining tissue. V4 applied Sureprep around the outside of the pressure ulcer, applied a thick cotton dressing and secured the dressing with dated bordered gauze. V4 removed gloves, washed her hands with soap and water, donned new gloves and assisted R2 to lay completely over, face and left abdomen down to expose R2's coccyx pressure ulcer dressing. R2's pressure ulcer dressing was dated 3/04/25 and had V4's initials to indicate when it was last changed. V4 stated (R2's) dressings need to be changed every day. (R2) is currently on antibiotic for Osteomyelitis, caused by these wounds. V4, Wound LPN removed R2's Coccyx Stage IV Pressure Ulcer Dressing bordered gauze dressing, absorbent pad and the wound bed strips. R2's coccyx had two, half-moon shaped, approximately two and a half inch opened wounds, connected by a half inch of healthy tissue. V4 stated The wound is connected, it is all one. The skin you see is like a bridge. V4 removed and discarded the soiled dressings, washed hands, and donned new gloves and cleansed R2's coccyx Stage IV pressure ulcer with four inch by four inch cotton pads and wound cleanser. V4 used a cotton swab to guide a piece of the gauze with wound cleanser under the bridged skin showing it is one Stage IV pressure ulcer. V4 patted the areas dry. V4 washed her hands donned new gloves. V4 cut opti-gel fiber material in a spiral like fashion, applied Santyl to the wound bed and inserted the spiraled material into the wound bed and tucked below the undermining tissue. V4 applied Sureprep around the outside of the coccyx pressure ulcer, applied a thick cotton dressing and secured the dressing with dated bordered gauze.</p> <p>On 3/6/25 at 2:55 pm V4, Wound/Licensed Practical Nurse stated We had some problems with the floor nurses doing the treatments. I thought we fixed the problem, but apparently not.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/6/25 at 3:05 pm V2, Director of Nursing (DON) provided the facility policy Pressure Injury Assessment and Treatment Guideline - QA (Quality Assurance) Document dated January 2025. V2 stated wound dressing should be dated and initialed by the nurse that completes the treatment. There have been some issues with agency nurses not completing the treatments.</p>		