

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006860</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>11/04/2016</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>ODD FELLOW-REBEKAH HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 LAFAYETTE AVENUE EAST MATTOON, IL 61938</b>
--	---

(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
--------------------	--	---------------	---	--------------------

S 000	Initial Comments  Annual Licensure and Certification Survey  Validation Survey for Subpart U: Alzheimer Unit  Odd Fellow-Rebekah Home is in substantial compliance with Subpart U, 77 Illinois Administrative Code 300.7000.	S 000		
S9999	Final Observations  Statement of Licensure Violations  300.610a) 300.1210b) 300.1210d)6) 300.1220)b)3) 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 b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological	S9999	<p><b>Attachment A</b> <b>Statement of Licensure Violations</b></p>	

Illinois Department of Public Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE  
11/23/16

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006860</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>11/04/2016</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>ODD FELLOW-REBEKAH HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 LAFAYETTE AVENUE EAST MATTOON, IL 61938</b>
--	---

(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	<p>Continued From page 1</p> <p>well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:</p> <p>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:</p> <p>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.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006860</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/04/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ODD FELLOW-REBEKAH HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 LAFAYETTE AVENUE EAST MATTOON, IL 61938</b>
--	---

(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	<p>Continued From page 2</p> <p>Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These requirements were not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to implement targeted interventions on two previous falls so as to prevent a third fall with the same identified root cause for one resident (R29). This failure resulted in R29 falling and sustaining a laceration to the forehead and spinal fractures at T8 and T9. R29 is one of twelve residents reviewed for falls in the sample of 23.</p> <p>Findings include:</p> <p>R29's Physician Order Sheet (POS) dated September 2016 includes the following diagnoses: Dementia-Lewy Body, Anxiety, Atrial Fibrillation, Hypertension, Congestive Heart Failure, Vision Impaired, Muscle Weakness and Gait/ Mobility Abnormality. The same POS documents that R29 is to receive a Nebulizer (breathing) treatment of Ipratropium and Albuterol scheduled four times a day (8:00 am, 12:00 pm, 4:00 pm and 8:00 pm).</p> <p>Lexi - Comp Drug Reference Handbook 12th Edition dated September 19, 2001 documents "...based on the Albuterol component : Use with caution in patients with Hypertension..Adverse reactions...Cardiovascular: Angina, Atrial Fibrillation, chest discomfort, extrasystoles, flushing, dizziness, Hypertension, palpitations and</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006860</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/04/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ODD FELLOW-REBEKAH HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 LAFAYETTE AVENUE EAST MATTOON, IL 61938</b>
--	---

(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	<p>Continued From page 3</p> <p>tachycardia...."</p> <p>R29's Fall Assessments dated 8/5 and 8/7/16 document R29 as high risk for falls. The above Fall Assessments do not address R29's nebulizer treatment of Ipratropium and Albuterol (Duoneb).</p> <p>The facility policy titled "Fall Assssment, Risk Identification and Management Policy dated 3/20/12 documents that the fall assessment may address assessment of factors listed but not limited to the following: Mental Status, Age, general state of health, mobility, previous falls and Medications which may cause dizziness."</p> <p>The Minimum Data Set (MDS) dated 8/8/16 documents R29 as severely cognitively impaired, Visually impaired, not steady, only able to stabilize self with staff assistance and needs two plus staff members for assistance in transfers.</p> <p>The facility reports titled "Occurrence Report" and "Fall Investigation" document R29 with the following falls and possible root causes:</p> <p>7/29/16 - Observed on floor sitting at 8:20 pm, had gotten up to go to the bathroom and prior to this R29 had a breathing (nebulizer) treatment in recliner (at 8:00 pm) and was put to bed. Intervention(s) - pressure alarm, make more room for accommodating resident. No intervention is identified for possible root cause of nebulizer treatment.</p> <p>8/2/16 - Observed on floor sitting at 5:35 pm, transferred from wheelchair to bed. Intervention(s) - hipsters and fifteen minute rounding</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006860</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/04/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ODD FELLOW-REBEKAH HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 LAFAYETTE AVENUE EAST MATTOON, IL 61938</b>
--	---

(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	<p>Continued From page 4</p> <p>8/5/16 - Observed on floor on back at 8:20 pm, transferring from bed to go to the bathroom. Possible root cause documented as Nebulizer treatment (scheduled 8:00 pm). Interventions - Habit training program, low bed and non-skid socks. There is no targeted intervention documented for the possible root cause of the nebulizer treatment.</p> <p>9/13/16 - Observed on floor lying face down at 4:20 pm, attempting to get out of wheelchair. Possible root cause documented as Nebulizer treatment (scheduled 4:00 pm). Interventions - Wedge cushion to wheelchair. There is no targeted intervention documented for the possible root cause of the nebulizer treatment</p> <p>On 11/4/16 at 8:55 am, E19 Registered Nurse stated that R29 was given a hand held nebulizer treatment while sitting in R29's wheelchair. E19 stated that E19 had left the room. E19 stated shortly thereafter E19 heard R29 yelling and went to R29's room and found R29 lying face down on the floor. R29 complained of back pain and had a cut on the forehead. E19 acknowledged that it was normal routine to leave R29 with the nebulizer treatment and continue with E19's medication pass. E19 stated "I won't make the mistake of leaving a resident with a nebulizer treatment alone again."</p> <p>On 9/14/16 the facility faxed a report titled "Report to Illinois Department of Public Health" documenting on 9/13/16, R29 was injured after a fall. The report documents that R29 was left alone in R29's room taking a nebulizer treatment per self. R29 was then heard yelling and the nurse (E19, Registered Nurse) came to R29's room and observed R29 lying on the floor with a 2 milliner laceration to the forehead. R29 was sent</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  IL6006860	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/04/2016	
NAME OF PROVIDER OR SUPPLIER  ODD FELLOW-REBEKAH HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 201 LAFAYETTE AVENUE EAST 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	<p>Continued From page 5</p> <p>to the emergency room for evaluation and treatment. R29 returned to the facility and the facility was informed that R29 had 8th and 9th healing rib fractures and spinal transverse process fractures at T8 and T9.</p> <p>The Emergency Room Report dated 9/13/16 documents that R29 had an unwitnessed fall while finishing a nebulizer treatment and that facility staff think she was attempting to go to bed. R29 is noted to have back pain.</p> <p>The Hospital Computerized Tomography report dated 9/13/16 documents the following on R29: "Status Post Fall.....Impression 1. Right Posterior 8th and 9th healing Rib fractures. 2. Right Transverse Process Fractures of T8 and T9, acute inn appearance." The report is signed by Z1, Radiologist.</p> <p>A facility policy titled "Self Administartion of Medication Protocol" dated 10/2005 documents "If the resident wishes to self medicate, the Interdisciplinary Team (IDT) must assess the resident's cognitive, physical and visual abilities. If the IDT determines that the resident is not capable, medications will be administered by the nurse."</p> <p>E2, Director of Nursing acknowledged on 11/3/16 at 1:15 pm, R29 was not cognitively intact to self administer R29's own medication. E2 acknowledged the medication of Duoneb/Nebulizer treatment was listed as a possible root cause for R29's falls and there were no targeted interventions for this. E2 stated "We missed it." E2 stated that no assessment for self-administration of medication had been done on R29.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006860</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>11/04/2016</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>ODD FELLOW-REBEKAH HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 LAFAYETTE AVENUE EAST MATTOON, IL 61938</b>
--	---

(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	<p>Continued From page 6</p> <p style="text-align: center;">(B)</p> <p>300.670a) 300.670c)1) 300.670c)2) 300.670c)3)</p> <p>Section 300.670 Disaster Preparedness</p> <p>a) For the purpose of this Section only, "disaster" means an occurrence, as a result of a natural force or mechanical failure such as water, wind or fire, or a lack of essential resources such as electrical power, that poses a threat to the safety and welfare of residents, personnel, and others present in the facility.</p> <p>c) Fire drills shall be held at least quarterly for each shift of facility personnel. Disaster drills for other than fire shall be held twice annually for each shift of facility personnel. Drills shall be held under varied conditions to:</p> <ol style="list-style-type: none"> <li>1) Ensure that all personnel on all shifts are trained to perform assigned tasks;</li> <li>2) Ensure that all personnel on all shifts are familiar with the use of the fire-fighting equipment in the facility; and</li> <li>3) Evaluate the effectiveness of disaster plans and procedures.</li> </ol> <p>This requirement was not met as evidenced by the following:</p> <p>Based on interview and record review, the facility</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6006860</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>11/04/2016</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>ODD FELLOW-REBEKAH HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>201 LAFAYETTE AVENUE EAST MATTOON, IL 61938</b>
--	---

(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	<p>Continued From page 7</p> <p>failed to perform the following required disaster drills since the last annual survey on 10/28/2015: one drill for first shift, two drills for second shift, two drills for third shift. This has the potential to affect all 113 residents in the facility.</p> <p>Findings include:</p> <p>The facility Disaster Drill record (undated) documents one disaster drill (Tornado Drill, 4/27/2016) since the last annual survey on 10/28/2015.</p> <p>On 11/4/2016 at 10:03 AM, E20 (Maintenance) acknowledged the 4/27/2016 disaster drill was the only drill completed for the previous year.</p> <p>The facility Disaster Plan (undated) documents in Section 14: "Fire drills shall be held at least quarterly for each shift of facility personnel. Disaster drills for other types of emergency events shall be held twice annually for each shift of facility personnel."</p> <p>The Resident Census and Condition of Residents Report dated 11/1/2016 documents 113 residents residing in the facility.</p> <p style="text-align: center;">(B)</p>	S9999		
-------	---	-------	--	--