Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006860	A. BUILDING: ______ B. WING ______	C 02/23/2022

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

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S 000	Initial Comments Facility Reported Investigation (FRI) to Incident 2-6-22/IL143815	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 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 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 care needs of the resident. 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: 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. These Requirements were Not met evidenced by: These failures require more than one deficient practice statement. A. Based on observation, interview, and record review, the facility failed to provide safety and supervision to prevent falls by failing to implement post fall interventions. This failure resulted in R1 subsequently falling on two additional occurrences and sustaining head trauma and a hip fracture requiring surgical intervention. This failure affects one of four residents (R1) reviewed for accidents on the total sample list of six. B. Based on interview, and record review, the facility failed to supervise and contain a potentially hazardous chemical for one of four residents (R5) reviewed for accidents on the total sample list of six. Findings include: a. R1's fall risk assessments completed on 12/14/21, 1/12/22, 1/27/22, and 2/1/22 document a risk score of 65, indicating R1 is at high risk for falls.	S9999		

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S9999	Continued From page 2 R1's medical record documents on 1/27/2022 at 8:51 PM, "Resident was sitting in the day room and fell out of recliner and hit her head." R1's post fall occurrence reports documents, on 1/27/22 at 8:45 PM, "resident was sitting in day room eating a snack then stood up and fell forward. Injuries: Bruising to the left side of the forehead measuring 7 centimeters by 5 centimeters, bruise is purple in color. R1's post fall investigation form documents, resident had been toileted at 8:00 PM layed down and tried to get out of bed on her own, resident was brought to the day room for snacks. R1's Fall Investigation Analysis form documents, "What type of assistance was the resident receiving at the time of the fall: resident alone or unattended. What appears to be the root cause of this fall: Unaware of safety needs due to cognitive impairment. Describe interventions to prevent future falls: Keep resident in visual observation when up in wheelchair." R1's medical record documents on 1/31/22 at 10:15 AM, "Heard noise, noted resident sitting on floor in hall near nurses station, leaning against an office door. Noted raised area to back of head, no bruising or open areas seen at this time. Alert with normal confusion, stating "help me up", continues to try standing up after assisting her into the wheelchair." R1's post fall occurrence report documents, on 1/31/22 at 10:15 AM, "heard noise, saw resident sitting on buttocks by wheelchair, back of head against office door. Injuries: head trauma, center side of back of head. Care prior to fall, visually observed on 1/31/22 at 10:10 AM. R1's post fall investigation form documents,"Where did fall occur: Hallway, Fall Summary: found on floor	S9999		

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(unwitnessed). Other: Had been trying to stand up all morning. Possible contributing factors to help identify root cause: yelling out trying to get up by self out of chair. R1's Fall Investigation Analysis form documents, "What type of assistance was the resident receiving at the time of the fall: Resident alone or unattended. What appears to be the root cause of this fall: Advancing disease process. Describe intervention to prevent future falls: Provide one on one interaction, socialization."

R1's medical record documents on 2/6/2022 at 3:36 PM, "Resident observed on floor of corridor. Resident assisted to bed. Resident was resting in bed and began to complain of pain to left leg. Received order to send to Emergency Room for evaluation/treatment."

R1's post fall occurrence report documents, on 2/6/22 at 3:15 PM, "Nurse observed resident on floor laying on back with wheelchair beside resident. Resident stands up by pulling self up with rails in hallway, redirected to sit down, resident is non compliant. Care prior to fall: Visually observed on 2/6/22 at 3:10 PM. R1's Post Fall Investigation form documents, "Where did fall occur: Hallway, Fall Summary: found on floor (unwitnessed). R1's Fall Investigation Analysis form documents, "What type of assistance was the resident receiving at the time of the fall: Resident alone or unattended. What appears to be the root cause of the fall: Unaware of safety needs due to cognitive impairment. Describe intervention to prevent further falls: Transferred to hospital for evaluation and treatment."

R1's Hospital History and Physical reports document, "service date/time: 2/7/22 at 8:21 AM,

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S9999	Continued From page 4 Chief Complaint: Unwitnessed fall at nursing home. History of present illness: presented to the emergency room yesterday afternoon (2/6/22) after having an unwitnessed fall at nursing home. The patient is a long term nursing home resident and has chronic dementia with pseudobulbar affect. In the emergency department she was evaluated and determined to have a left femoral neck fracture and multiple contusions. She was admitted for further care, nursing staff reports that overnight the patient was yelling, screaming and in significant pain with bed position changes. Physical exam: Skin: Bruising to face. Assessment/Plan: 1) fall at nursing home, 2) Left Femoral Neck Fracture 2/6/22, 3) scalp hematoma. Xrays of the left hip and pelvis confirm left femoral neck fracture. CT of the brain shows a large subgaleal scalp hematoma. Xray of hips dated 2/6/22 documents: indications: multiple falls, pain. Impression: Left hip fracture. Xray of femur bilateral 2/6/22 documents: Findings: oblique fracture of intertrochanteric portion of the femur with medial angulation of the distal fracture fragment. Impression: Left hip fracture. R1's Hospital discharge paperwork documents:1) fall at nursing home, 2) left femoral neck fracture 2/6/22 status post hemiarthroplasty 2/7/22, 3) scalp hematoma." R1's care plan initiated on 6/17/2021 documents, "I am at risk for falls related to unsteady gait, poor balance, weakness. I am here from the hospital. I fell and have had a broken hip repaired. I hope to rehab and then will remain long term here. Interventions: date initiated: 1/28/22, Keep resident in visual observation when up in wheelchair. On 2/23/22 at 12:19 PM, V6 LPN stated I was	S9999		

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working when R1 fell on 2/6/22. I was on the hallway in another patients room, the other nurse who was working the floor (V8 Licensed Practical Nurse) was coming back to the floor from break and noticed R1 on the floor by the water fountain around the nurses station. V8 assessed her and then had staff get me. It was an unwitnessed fall, R1 was not in visual observation of staff and no staff members saw her fall, we were in rooms getting other residents up for the meal, R1 was not being visually observed at the time of her fall.

On 2/23/22 at 1:50 PM V3 Assistant Director of Nursing stated, "I do post fall investigations. On 1-27-22 R1 was found sitting in day room eating a snack and stood up and fell, poor safety needs due to impaired cognition. Intervention: staff were to keep R1 in visual observation while up in wheelchair. On 1-31-22 was found sitting on buttocks, by office door, anxious getting up an down, advancing dementia. Staff were to provide one to one calming activities with resident and social interaction when anxious. This fall was unwitnessed. R1 had a raised area to back of head. On 2-6-22 staff found R1 on the floor on back with wheelchair bedside her. R1 has returned from the hospital and is not doing well, R1 is on comfort care. Keeping R1 in visual observation could be she is down the hallway from the nurses station but staff should be able to see her."

On 2/23/22 at 11:00 AM, R1 was lying in bed in R1's room, R1 had fading yellow, purple, maroon discolorations surrounding the entire left eye area and left forehead area. R1 did not respond to verbal stimuli, R1's eyes remained closed.

The facility's policy, with a revision date of April 2019, titled "Resident Care Policy and Procedure:

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Fall assessment and Management Policy" documents, "Policy: It is the policy of the facility to assess resident's fall risk on admission, quarterly, and with each fall. This will help facilitate an interdisciplinary approach for care planning to appropriately monitor, assess and ultimately reduce injury risk. Factors related to the risk will be addressed and care planned. Procedure: I: Fall risk and planning assessment: F: Interventions will be based on the fall risk assessment and the circumstances surrounding the risk for injury or the actual injury or fall. II: Resident fall: C- Care planning after a fall: 1- A licensed nurse will consult with the resident's care givers and other interdisciplinary team members in regards to future interventions and resident specific risk factors."

b. R5's medical record documents on 2/14/2022 at 7:01 PM, "Certified Nursing Assistant reported to nurse witnessing (R5) put acetone bottle to her lips. CNA states she is unsure if resident took drink or not. Nurse evaluated, no lesions in mouth, no behavior to suggest resident might have taken drink (no signs and symptoms of upset stomach, no acetone smell apparent on resident or resident breath.) Physician contacted and stated to contact poison control and follow their directions for care. Poison control contacted, states that acetone may have intoxicating effects and cause Gastrointestinal Upset if consumed, but is unlikely to cause injury. Poison control suggests to monitor patient and contact Physician if any concerns arise. Monitoring closely."

On 2/23//22 at 1:25 PM, V9 Certified Nursing Assistant, stated "I was standing away from (R5), (R5) was at the nurses station, I noticed (R5) had a cap to something in her hand. I then seen (R5) tipping a bottle up to her mouth, I immediately ran

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S9999	Continued From page 7 to (R5) and took the bottle and cap away and went and got V6 (Licensed Practical Nurse) immediately. V6 then assessed her. Acetone (finger nail polish remover) is something that is not to be left at any time on the unit, it is always locked up. I had not seen the bottle lying out anywhere on the unit that day, I do not know where (R5) obtained it from." On 2/23/22 at 12:50 PM, V6 LPN stated I was down the hallway in another residents room and the CNA (V9) came and got me and told me that (R5) was at the nurses station holding a bottle of acetone (nail polish remover) up to her mouth. (V9) had taken the bottle away immediately and placed the lid back on the bottle. We do not know were (R5) got the bottle from, there was new activity aide working on the unit that day and I don't know if she was not aware and accidentally left it out or what, we had not seen it sitting out earlier. Normally activities keep it locked up on the unit. I immediately did an assessment on (R5). (R5) did not have any acetone smell around or in her mouth, (R5) was not spitting anything out of her mouth, (R5) was not grabbing at her throat. I immediately notified the physician who had me contact poison control. We continued to monitor (R5) closely all evening and (R5) never exhibited any symptoms of ingestion of the acetone." On 2/23/22 at 11:50 AM, V2 Director of Nursing stated, "I was not aware of the acetone incident until yesterday (2/22/22). Acetone containing products (any chemically hazardous products) should be used and put away (locked up) immediately, it is not to be left out for residents to find." "A"	S9999		

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