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 _____	12/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ODD FELLOW-REBEKAH HOME	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
S 000	Initial Comments Annual Licensure and Certification survey	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2) 300.610a) 300.1210a) 300.1210b) 300.1210d)5) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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 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: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.	S9999		

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S9999	Continued From page 2 These requirements were not met as evidenced by: Based on observation. interview, and record review the facility failed to implement interventions to prevent a pressure ulcer and failed to assess and treat a facility acquired pressure ulcer for a resident. These failures affect one resident (R265) of three residents reviewed for pressure ulcers in a sample list of 58 residents. These failures caused R265 to develop two facility acquired unstageable pressure areas and an additional stage II pressure area. Findings include: R265's Care Plan initiated 12/1/23 includes the following diagnoses: Status Post Spinal Surgery, Diabetes with Neuropathy, Spinal Stenosis, Congestive Heart Failure, Generalized Anxiety Disorder, Depression. R265's Braden Skin Risk Assessment dated 12/1/23 documented R265 is at risk for skin breakdown. R265's Wound Assessments dated 12/1/23 document R265 was admitted 12/1/23 with a surgical wound to upper midback, Reddened area to Right hip, Excoriated/reddened area to coccyx, and a reddened area to right iliac crest. R265's Care Plan initiated 12/1/23 documents (R265) "at risk for impaired skin integrity due to impaired mobility, Diabetes Mellitus, poor appetite and recent surgery. Provide (R265) with a pressure reduction mattress. May use a pressure reduction cushion if uses a wheelchair. Remind/assist (R265) to shift weight/reposition at least every two hours. Ensure pressure reduction on any areas that might be impaired with	S9999		

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S9999	Continued From page 3 education/assistance." R265's Physician's orders include admission orders dated 12/1/23 for Physical and Occupational therapy. On 12/4/23 at 1:34 AM, R265 was being lifted with a sling type mechanical lift by V30 Certified Nurse's Aide (CNA) and V31 CNA and transferred to a bariatric wheelchair. There was no pressure relieving cushion in the chair and no pressure relieving mattress on R265's bed. R265 stated "this is the first time I've been up since I came in Friday (12/1/23)." V30 stated, "They just brought out the wheelchair from downstairs for (R265). (R265) will have therapy for the first time today." R265's Treatment Administration Record (TAR) has an order dated 12/1/23 to assess skin daily and document "I" for intact and "W" for wound every night shift for skin integrity. R265's TAR for 12/1/23 through 12/6/23, documents I indicating R265's skin was intact." On 12/6/23 at 9:50 AM, V30 and V33 CNAs were providing incontinence care and catheter care for R265. When R265 was turned to her left side to be cleaned a three centimeter (cm) by four cm, dark purple edematous, unstageable deep tissue injury was visible to R265's right buttock near the gluteal cleft. A two cm by three cm dark purple edematous, unstageable deep tissue injury was visible to R265's left buttock near the gluteal cleft. And an eight cm by one half cm, Stage II pressure area was noted in the crease under R265's right buttock along where the catheter tubing had been laying. R265 stated "My butt really hurts. The nurses haven't looked at it and I don't get any dressing or anything. I'd like them to do something for it. It's been sore for at least a	S9999		

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S9999	Continued From page 4 couple days." V33 stated "The wound nurse hasn't been in since (R265) got here. She'll be here today so we've just been keeping it clean. There was no documentation of assessment, physician's notification, or treatment order in place for these areas. On 12/6/23 at 2:00 PM V32, Wound Nurse stated "I was not aware of the deep tissue injuries or the pressure area under (R265's) right buttock. I have assessed them now and there are two unstageable Deep tissue Injuries on (R265's) buttocks and a new pressure area under R265's right buttock on her thigh. I will notify the doctor and get a treatment order." The facility's policy Wound and Ulcer Policy and Procedure revised 1/10/18 states "It is the policy of this facility to provide nursing standards for assessment, prevention, treatment, and protocols to manage residents at any level of risk for skin breakdown and for wound management. " This policy also documents "Moderate risk protocol Daily skin check completed by direct care staff. The 'skin observation report' may be used to communicate skin observation to the nurse." (B) Statement of Licensure Violations (2 of 2) 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and	S9999		

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S9999	Continued From page 5 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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	S9999		

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S9999	Continued From page 6 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: Based on observation, interview, and record review the facility failed to provide a safe transfer and implement care plan interventions for three (R87, R265, R39) of eight residents reviewed for Accidents in a sample list of 58 residents. These failures resulted in R39 sustaining an upper arm (Right Humeral) fracture and pelvic (Inferior Pubic Ramus) fractures and R87 sustaining pelvic (Superior and Inferior Pubis Rami) fractures. R39 and R87 required emergency services and hospitalization. Findings include: 1.) R87's Medical Diagnoses List documents R87's medical diagnoses of Dementia, Disorders of Bone Density and Structure, Hyperosmolality	S9999		

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S9999	Continued From page 7 and Hypernatremia, Kidney Failure and Closed Fracture of Pubis. R87's Minimum Data Set (MDS) dated 10/18/23 documents R87 as severely cognitively impaired. This same MDS documents R87 uses a walker for mobility and requires supervision with transfers and walking. R87's Fall Risk Evaluation dated 7/25/23 documents R87 as a high fall risk. R87's Fall Investigation dated 8/6/23 documents "(R87) was ambulating without walker and assistance also had plain socks on. (R87) complained of pain on the inside of Left groin area. Pain when Range of Motion (ROM) performed. Placed in a standing position." This same fall investigation documents R87's shoes were in path of (R87). R87's Final Incident Report to State Agency dated 8/14/23 documents (R87) was observed on the floor in her room on 8/6/23. It was determined that (R87) had Superior and Inferior Pubic Rami Fractures. Facility investigation of the fall determined that (R87) had been in her room wearing only regular socks when she states 'I saw a bug fly to the floor so I got up to kill it and slipped to my bottom.' R87's Care Plan intervention dated 4/18/23 instructs staff to have R87 wear appropriate shoes and monitor for unsteady gait, poor balance, poor posture, dizziness and fatigue. R87's Nurse Progress Note dated: --8/6/23 at 11:40 PM documents "(R87) yelled and (V26) Certified Nurse Aide (CNA) observed (R87) sitting on buttocks in the middle of the her	S9999		

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S9999	Continued From page 8 floor. Observed (R87) sitting on buttocks in her room. (R87) stated that she went to kill a bug and sat down on the floor. (R87) stated that she had pain on the inside a little to the left of her groin area. (R87) ambulated a little slower than usual. (R87) laid down in bed . Physician (MD) are aware. MD will assess (R87) when he comes in." --8/7/23 at 9:10 AM documents "(R87) having pain left hip area. Physician (MD) gave new order for X-Ray. Portable x-ray ordered due to Dementia diagnosis. Portable x-ray ordered three views to left hip due to post fall, pain and immobility. --8/7/23 at 11:25 AM documents Facility Interdisciplinary Team (IDT) Review: (R87) Female resident who is alert and oriented X two. (R87) needs supervised to limited assistance with Activities of Daily Living (ADLs). (R87) was observed sitting on her buttocks on her room floor on 8/6/23 at 11:40 PM. Assessed: vital signs within normal limits, neurological checks initiated, pain with Range of Motion (ROM) performed, placed in a standing position. (R87) ambulating without her walker and had regular socks on feet. (R87) stated, "was getting up to kill a bug that flew off her bed onto the floor and slid to the floor on her buttocks." --8/7/23 at 4:11 PM documents "(R87) continues to have pain. Spoke with Physician (MD) office to have (R87) sent to emergency room (ER) for evaluation and treatment since results have still not been read. MD gave order for ER for evaluation and treatment." --8/7/23 at 8:08 PM documents "Hospital called and stated (R87) has Superior and Inferior Left Pubic Fractures." --8/8/23 at 1:41 PM documents "(R87) complains of Pelvic pain. (R87) Refusing to get out of chair and stand due to pain. (R87) Stated she would just go to the bathroom in her depends because	S9999		

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S9999	Continued From page 9	S9999		

the pain of standing was so bad she was going to have a heart attack."
--8/9/23 at 4:18 PM documents Resident returned from appointment with (V27) Orthopedic Surgeon regarding Pubic Rami Fractures. (R87) is to be up walking with walker as much as possible. Fractures should heal on their own."

R87's Orthopedic Surgeon (V27) Progress Note dated 8/9/23 documents "(R87) does have a Pubic Rami Fracture but will heal on its own and not need surgery. (R87) can walk on her own with a walker as allowed and tolerated."

On 12/5/23 at 9:55 AM R87 walked independently to R87's room door. (V7) Activity Director walked over to R87, invited R87 to join in on activity. (V7) stated to R87 'Come on over and join us'. R87 then walked back into R87's room and returned in two minutes with seat cushion and purse. R87 then walked independently with shuffling gait from room the activity area across the hall. V7 did not encourage R87 to use walker when ambulating.

On 12/5/23 at 10:05 AM (V7) stated "(R87) walks by herself all the time back and forth from her room to the dining/activity area. I guess I should have encouraged (R87) to use her walker but I never see her use it so I guess I thought she didn't need it anymore."

On 12/5/23 at 10:10 AM V8 Dementia Unit Director stated R87 is a high fall risk and should be using her walker when ambulating. V8 stated "(R87) did fall a few months ago and got a fracture. (R87) can walk independently but we (staff) should all encourage her to use her walker. (V7) Activity Director should have encouraged (R87) to use her walker when walking to the

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S9999	Continued From page 10 activity." On 12/6/23 at 9:45 AM V9 Assistant Director of Nurses (ADON)/Fall Nurse stated "(R87) fell because the staff weren't watching her. We (facility) know (R87) gets up and down all the time. After (R87) fell, they (staff) should have used the total body mechanical lift to get her back up but instead they just got her up and let her start walking independently again. They (staff) even documented that (R87's) gait was slower than usual. (R87) was complaining of pain at the time of the fall. (V18) Licensed Practical Nurse (LPN) and (V26) Certified Nurse Aide (CNA) should not have gotten her up. (V18) should have just called the ambulance from there." On 12/6/23 at 1:05 PM V19 Medical Director stated the facility did not follow R87's careplan to help prevent R87's fall. V19 stated "(R87) has a very short term memory. (R87) does not remember anything you tell her for any length of time. That is why (R87) lives in a Dementia unit. The facility staff should have made sure (R87) was being monitored more closely." V19 stated R87 fell because staff did not ensure R87's safety. V19 stated "(R87) fell at this facility which resulted in her fractures. I do not recall (V18) reporting pain for (R87). Normally, I would just have the resident sent directly to the emergency room for X-Rays. Especially with a Dementia resident who is not cognitively able to accurately report exact source of pain. I would have just sent (R87) to the emergency room. Whether (R87) obtained the fractures because of the fall or because the staff got her up right after the fall without the use of the total body mechanical lift is a mute point. Either way, (R87) obtained the fractures due to the facility not following their own policies and careplan guidelines."	S9999		

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S9999	Continued From page 11 2.) R39's Medical Diagnosis list documents R39's medical diagnoses as Alzheimer's Disease, Dementia, Parkinson's Disease, Epilepsy with Complex Partial Seizures, Anxiety Disorder, Unsteady on Feet, Right Pubis Fracture, Muscle Weakness and Lack of Coordination. R39's Minimum Data Set (MDS) dated 9/4/23 documents R39 as severely cognitively impaired. This same MDS documents R39 requires extensive assistance of one person for transfers, bed mobility, toileting, personal hygiene and limited assistance of one person for walking in room. R39's Care Plan intervention dated 11/5/18 instructs staff to identify factors that increase R39's risk for falls such as obstacles, unmet needs or medications, keep pathways clear and to eliminate factors that may increase my risk for fall/injury. This same careplan documents an intervention dated 4/26/19 that instructs staff to ensure R39 wears non-skid socks. R39's Fall Risk Evaluation dated 10/5/23 documents R39 as a high fall risk. R39's Nurse Progress Note dated: --11/9/23 at 6:03 PM documents "(R39) was observed on the floor. (R39) stated she was getting her walker that was in between the bathroom and her room." --11/9/23 at 6:05 PM documents "(R39) started to complain of her head hurting and her right side hurting. Physician (MD) was notified and gave orders to send out to emergency room to treat and evaluate at 5:00 PM." R39's Fall Investigation dated 11/9/23 documents	S9999		

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S9999	Continued From page 12 R39 obtained a bruise on Right Hip and Head Trauma on Right side of back head. This same fall investigation documents staff applied an ice pack to R39's head, R39 stated 'I hit my head' and '(R39) was trying to go to the bathroom to get her walker. R39's Final Incident Report to State Agency dated 11/17/23 documents R39 fell at facility on 11/9/23 at 11:45 AM. This same report documents R39 was sent to the emergency room where she was admitted with Right Humeral Fracture and Inferior Pubic Ramus Fracture. This same report documents R39's statement 'I was trying to get my walker. I left it in the bathroom. I hit my head.' R39's Hospital Record dated 11/9/23 documents R39 sustained a Right Humeral Fracture and Inferior Pubis Rami Fracture from unwitnessed fall at facility on 11/9/23. On 12/5/23 at 2:00 PM V9 Assistant Director of Nurses (ADON)/Fall Nurse stated R39 fell on 11/9/23 obtaining a Left Humeral Fracture and Inferior Pubis Rami Fracture due to fall at facility. V9 stated the staff had been in R39's room 15 minutes prior to fall to attempt to get R39 out of bed. V9 stated R39 refused to get out of bed so the staff left R39 in her room alone and forgot to put the walker back within her reach. V9 ADON/Fall Nurse stated "(R39) probably would not have fallen that time if the staff had put her walker next to her. But since (R39) had to get her own walker out of the bathroom, (R39) was apparently unsteady and fell. (R39) ended up getting fractures that could have been prevented if our staff would have just left (R39) her walker." On 12/6/23 at 1:00 PM V19 Medical Director	S9999		

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 _____	12/06/2023

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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S9999	Continued From page 13 stated "Dementia residents are known for being forgetful. The staff is there to help give verbal reminders to help keep the residents safe. I remember being told about this fall for (R39). (R39) is more apt to use her walker if it is within her sight and reach. (R39) has very poor safety awareness and is not able to make safe decisions for herself. Unfortunately for (R39) the facility did cause the fall which was the cause of the fractures. This fall was preventable. Maybe others might not be, but this fall for (R39) could have been prevented." The facility policy titled 'Safe Resident Handling Program' revised 3/18/18 documents if a resident falls to the floor, the resident will be first assessed by a nurse. If the resident is deemed medically appropriate to transfer from the floor, a full size mechanical lift will be used. If the resident is not medically appropriate to transfer from the floor, emergency medical technicians will be notified and said technicians will transfer the resident. 3. R265's Care Plan initiated 12/1/23 includes the following diagnoses: Status Post Spinal Surgery, Diabetes with Neuropathy, Spinal Stenosis, Congestive Heart Failure, Generalized Anxiety Disorder, Depression. On 12/4/23 at 1:34 AM, R265 was being lifted with a mechanical lift by V30, Certified Nurse's Aide (CNA) and V31 CNA and transferred to a bariatric wheelchair. R265 was lying on the bed with a split leg sling positioned under her. V30 placed the lift hook in the blue loop on R265's left upper body. V31 then attached the left upper loop. V30 and V31 attached the leg loops to the mechanical lift but did not cross the loops. R265 was then raised in the lift. V30 rolled the lift from under the bed but did not spread the legs to	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ODD FELLOW-REBEKAH HOME	201 LAFAYETTE AVENUE EAST MATTOON, IL 61938

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S9999	Continued From page 14 provide a safe base of support prior to rolling the lift several feet across the room to the wheelchair. When the lift was in front of the wheelchair V30 spread the legs of the lift to place R265 in the wheelchair. V30 stated "I know the leg supports are supposed to be crossed before you lift, but (R265) doesn't like us to do that. I suppose I should have opened the legs before rolling (R265) to the wheel chair to keep the lift from tipping." On 12/5/23 at 11:00 AM, V2 Director of Nurse's stated "To keep the resident from slipping out of the sling while transferring, the straps on the split sling should be crossed between the residents legs and the legs (mechanical lift legs) should be in the open position to prevent tipping during transfer." (B)	S9999		