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 _____	R 01/25/2024

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 First Certification Revisit to Survey date 12/06/23	S 000		
S9999	Final Observations Statement of Licensure Violations 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 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	S9999		

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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.

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:

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Based on interview, and record review the facility failed to implement the non-skid footwear fall intervention. This failure resulted in R301 sustaining a fall with a right femur fracture, requiring surgical repair and extended hospitalization. R301 is one of three residents reviewed for falls on the sample list of 25.

Findings include:

R301's Minimum Data Set (MDS) dated 11/06/23 documents R301 had a Brief Interview of Mental Status score of three (3) out of a possible 15, indicating R301 has severe cognitive impairment. The same MDS documents R301 had a previous fall during the look back period for that assessment.

R301's Current (multiple dates) diagnoses sheet documents the following:
"Alzheimer's Disease, Dementia, History of Falls, Abnormal Gait, Unsteadiness on Feet, Muscle Weakness, Osteoporosis, Pulmonary Hypertension, and Abnormal Gait."

R301's Care Plan dated 11/06/23 documents the following: "FALLS: My safety awareness is compromised d/t (due to) Dementia. I am at risk for falls related to unsteady gait, poor balance, weakness. I am unsteady on my feet at times. I have a history of falling. * I will have no fracture or soft tissue damage from falls through the next review. Target Date: 02/06/2024.
The same Care Plan documents an intervention as of 08/15/22: "Assure resident has non-skid socks on at night. '(At times, I remove them)'."
The same Care plan was updated post-fall (01/12/24) documents: "Intervention: Discuss with family to have them bring in new slippers for

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resident. Date Initiated: 01/12/2024."

R301's Health Status Note dated 01/12/2024 at 03:26 am documents the following:"
Note Text: Res (R301) fell at 02:12 am, (V3, Physician/ Medical Director) called at 02:20 am and POA (V20, Power of Attorney) called at 02:47 am. Res. (resident) was taken by ambulance c/o (complaint of) right hip pain. Res has been moving back and fourth with help through the night, wanting to sit in her chair and lay down in her bed. Res. was toileted last at 01:30 am and also given fluids. After using the restroom she wanted to watch a basketball game. Res. has been on 15 (fifteen) min. (minute) check."

R301's Hospital "Progress Note" dated 01/21/2024 at 09:48 am documents the following: "Date of Admission: 01/12/2024. Reason for Admission: Patient (R301) with (had) unwitnessed fall at NH (nursing home) that resulted in Rt (right) displaced Femoral Neck fracture and is s/p (status/post) THA (Total Hip Arthroplasty- surgical procedure) on 01/12/24. Had hypotension (low blood pressure) and hypoxia (low blood oxygen level) post-op (after surgical operation) needing PCU (critical care unit) admission. Was dx'd (diagnosed) with bronchitis and started on Azithro (antibiotic medication), scheduled nebs (breathing treatment) and s/p (status post) lasix (diuretic medication) 20 mg IV (intravenous)
1. Subsequently she developed AMS (Altered Mental Status) and Neuro (Neurology department) consulted with EEG (electrical activity of the brain diagnostic test) showing Seizure activity, thus started on Phosphenytoin and Keppra (anticonvulsant medication)."

R301's "CNA (Certified Nursing Assistant) and

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Nurse Post-Fall Investigation" dated 01/12/24 at 2:12 am, documents R301 had on socks and slippers and just wanted to get up. The same "CNA and Nurse Post-Fall Investigation" is signed by V12, Licensed Practical Nurse (LPN) and V15, CNA.

R301's "Health Status Note Facility Interdisciplinary Team" dated 01/12/2024 at 4:42 pm documents the same as the above Health Status Note and adds the root cause and interventions as follows: " 'I (R301) stood up and fell down.' when asked what happened. Resident had slippers on feet. Walker was in use." " Intervention: Discuss with family to have them bring in new slippers for resident."

The facility "Fall Investigation Analysis-Quality Assurance" documents R301's fall 01/12/24 at 2:12 am as follows: "Factors observed at the time of the fall: (box checked) Resident lost Balance, (Box checked) Resident slipped 'give details' Improper footwear."

On 1/24/24 at 12:40 pm V2, Director of Nursing confirmed, R301's 01/12/24 fall investigation determined the root cause, was due to improper footwear, causing a gait imbalance as R301 tried to stand up from her recliner and walk. V2 also stated all staff knew R301 was at high risk for falls and R301 was supposed to wear non- skid footwear. 'It is care planned.' V2 acknowledged R301's fall 01/12/24 resulted in R301 sustaining a right femur fracture.

On 1/25/24 at 1:27 pm V15, Certified Nursing Assistant (CNA) stated V15, CNA was working with V13, CNA and had taken R301 to the bathroom, and assisted R301 to her recliner to watch television. V15, CNA stated "She (R301)

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was not wearing shoes or non-skid socks. She was wearing slipper socks, they were not the non-skid type. She was not wearing non-skid socks or shoes. We were not getting her up and dressed for the day when we put her in the recliner, or she would have had shoes on. When (V13) CNA went on break, the nurse (V12, LPN) found her (R301) on the floor. We did not get her up because she was hurt. We kept her on the floor until the ambulance came. They got her up on the gurney to transport her. The nurses had already done their assessment when the ambulance got here."

On 1/25/24 at 3:35 pm V12, LPN stated "I was a CNA for 20 years. I tell my CNA's to check every 15 minutes. I walk the halls myself too, I was in the hall and looked in on (R301). She was on the floor. I did a complete assessment on (R301), her neuros (neurological assessment) and vs (vital signs) were fine. She was in a lot of pain, her pelvis and right leg. I went and got another nurse (V14, Agency LPN) working on another unit. She confirmed my findings. She (R301) needed sent out (go to the hospital), even though the rest of the assessment was good, her pain needed to be assessed in ER (Emergency Room). (R301) had been assisted to bed to her chair several times over the course of the night, per her usual. She was not dressed for the day. She had on pajamas and slipper socks on. Not the non-skid type she is supposed to have on. Her family brings the slipper socks in, but we have non-skid to put on (R301). That is what she is supposed to have (wear), or shoes."

The facility "Fall Assessment and Management Policy" date as revised April 2019 documents the following:
"Policy: It is the policy of this facility to assess each resident's fall risk on admission, quarterly,

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S9999	Continued From page 6 and with each fall. This will help facilitate an interdisciplinary approach for care planning (interventions) to appropriately monitor, assess and ultimately reduce injury risk. Factors related to the risk will be addressed and care planned." (A)	S9999		