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 01/19/2021

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 Facility Reported Investigation (FRI) of 1/7/21 IL#130208	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210)d)6) 300.1220b)2) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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: 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. Section 300.1220 Supervision of Nursing Services b)The DON shall supervise and oversee the nursing services of the facility, including: 2)Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. These Requirements were not met evidenced by: Based on interview, and record review, the facility failed to implement an intervention from a previous fall which resulted in a recent fall, and subsequent injury for one cognitively impaired resident (R1). R1 was sent to the Emergency Room and treated for a blunt head injury, scalp	S9999		

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S9999	Continued From page 2 laceration, and skin tear to the hand after falling at the facility. R1 is one of three residents reviewed for falls in the sample of three. Findings include: R1's Face Sheet dated 1/15/21 documents R1 is diagnosed with Parkinson's Disease, Dementia, Muscle Weakness, Unsteadiness on Feet, Abnormalities of Gait and Mobility, and History of Falling. R1's Minimum Data Set dated 12/8/20 documents R1's cognitive status as moderately impaired. The same record documents R1 requires extensive assistance of at least one staff for transfers. R1's Fall Scale Assessment dated 12/8/20 documents R1 is at high risk for falls. R1's Progress Note Fall Interdisciplinary Team (IDT) Review dated 6/22/20 documents R1 slid from his recliner on 6/18/20 with no injuries. The same record documents the intervention for this fall was to disable R1's (electric-powered) recliner. R1's Progress Note Fall Interdisciplinary Team (IDT) Review dated 1/8/21 documents R1 was found on the floor in front of his recliner on 1/7/21. R1 had a laceration to the top of his head and right palm. R1 was sent to the Emergency Room and returned to the facility with four staples to his head and two sutures to his right palm. The same record documents the intervention for this fall was to disable R1's electric recliner. R1's Care Plan dated 12/2/19 documents the same intervention, to disable R1's electric	S9999		

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S9999	Continued From page 3	S9999		

recliner, for both of the falls that occurred on 6/18/20 and 1/7/21.

The Emergency Documentation dated 1/7/21 documents R1 was seen and treated in the Emergency Room after a fall on 1/7/21 which resulted in a blunt head injury, skin tear of the right hand, and laceration of the scalp.

On 1/15/21 at 12:50 PM V2 Director of Nurses confirmed R1 had a fall from his recliner on both 6/18/20 and 1/7/21. V2 also confirmed that the intervention for both falls was to disable R1's electric recliner by disabling the electric reclining function, and disconnecting the power box. V2 stated that electric power was still supplied to the recliner at the time of the fall. V2 stated she is not sure how R1's electric recliner got hooked back up to the power box but it should not have been hooked back up at all. V2 confirmed R1 was injured from the fall on 1/7/21 and was sent to the Emergency Room where he received staples to the head laceration and sutures to the skin tear on his right hand. V2 stated R1 is not safe to operate the electric recliner due to his decreased cognition and lack of safety awareness. V2 confirmed that R1's electric recliner should have been disabled after the 6/18/20 fall and should not have been hooked back up. V2 confirmed if R1's recliner would have stayed disabled like it should have, R1 might not have fallen out of it the way he did on 1/7/21.

The Resident Care Policy and Procedure dated April 2019 documents, "It is the policy of this facility to assess each 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

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S9999	Continued From page 4 to the risk will be addressed and care planned." " B "	S9999		