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 08/16/2021

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 Complaint Investigation: 2165604/IL136757	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3)5) 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 each resident's comprehensive resident care	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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: 3)Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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. 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.	S9999		

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S9999	Continued From page 2 These requirements were not met evidencded by: These failures require more than one deficient practice statement. A. Based on interview, and record review, the facility failed to identify, observe, assess, notify and implement targeted interventions to prevent the development and/ or worsening of an unstageable pressure ulcer for a resident. These failures include lack of skin assessment checks, bathing, repositioning assists, incontinence care assists, transfer assists for a resident who required extensive assistance, and hydration. This failure affects one R1 of three residents reviewed for pressure ulcers. R1 developed a stage IV pressure ulcer between 7/9/21 (admission) and 7/25/21. Findings Include: R1's skin assessment was not documented on admission 7/9/21, daily, or weekly until 7/20/21. On 7/20/21 R1's skin assessment documents that R1 was at high risk for skin breakdown. On 7/25/21 R1's progress note documents that pressure area over coccyx was noted. 3.5 centimeters wide by 3 centimeters deep with an unstageable depth and black in color. A wound treatment of MedaHoney and Calcium Alginate were applied to the area and the Physician, Power of Attorney and Wound Nurse were notified of this new wound. On 7/27/21 R1's undated wound notes documented by V10 Facility Wound Physician	S9999		

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S9999	Continued From page 3 described R1's wound as an unstageable pressure wound measuring 5.5 centimeters long by 3.5 centimeters wide by 0.5 centimeters deep. At that time, V19 Wound physician debrided 19.25 centimeters of "devitalized tissue and necrotic muscle surrounding the facial fiber." An order for Calcium Alginate with silver for once a day for 30 days with a gauze island dressing. Recommendations including elevating legs, floating heels while in bed, repositioning per facility policy, turning side to side, front to back every 1-2 hours, air loss mattress, daily Multivitamin, daily Vitamin C 500 milligrams, and a daily Zinc 220 milligrams. R1's Emergency Room Progress note dated 7/28/21 documents that R1 was taken to a neurology appointment and the neurologist sent R1 from the office to the Emergency Department for further evaluation due to leg weakness and dehydration. On 7/28/21 R1 was admitted to the hospital with the following diagnoses: Acute Kidney Infection, Dehydration, Failure to Thrive, Compression Fractures of L3 and L4, Spinal Stenosis, Cauda Equina Syndrome, and Sacral Decubital Ulcer. R1 did not return to the facility. On 7/29/21, R1 was seen by the hospital wound physician. R1 was recommended to have additional debridement of the sacral pressure ulcer. On 8/10/21 at 8:20AM V2 Director of Nursing stated, "We don't have daily skin checks for R1, R1 was high risk for skin breakdown." On 8/11/21 at 8:20AM V2 Director of Nursing stated, "There are several assessments that are	S9999		

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S9999	Continued From page 4	S9999		

supposed to be done upon admission including a nursing assessment, and skin assessment. I would expect repositioning every two hours and if wheelchair bound, a cushion in the chair. Keeping residents clean and dry with toileting and bathing at least once a week or more if possible. I have already started re-educating staff on documentation."

On 8/16/21 at 11:45AM, V8 Assistant Director of Nursing stated, "Staffing isn't our problem, it is not following the policy and doing the skin assessments on admission."

On 8/11/21 at 9:14AM, V9 Facility Wound Nurse stated, "I would expect staff to be repositioning residents every two hours, toileting to keep the skin dry, and to off load pressure areas to prevent pressure ulcers."

On 8/11/21 at 9:31AM V1 Administrator stated, "I would expect repositioning every 2 hours and sometimes more if required, every two hours for continence checking and our standard is two baths a week."

R1's Minimum Data Set dated July 19, 2021 documents R1 as an extensive assist for mobility, toileting, bathing, and transfers, R1 uses a wheelchair.

R1's most recent care plan dated 7/12/21 does not document an unstageable pressure wound nor interventions for the sacral pressure wound found on 7/25/21.

R1's Activities of Daily Living document dated July 2021 does not document repositioning on 7/12, 7/13, 7/15, 7/16, 7/17, 7/18, 7/19, 7/20, 7/21 and 7/23 of 2021.

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S9999	Continued From page 5 R1's Activities of Daily Living document dated July 2021 does not document incontinence care on 7/12, 7/13, 7/15, 7/16, 7/17, 7/18, 7/19, 7/20, 7/21, 7/23 or 7/28 of 2021. R1's Activities of Daily Living document dated July 2021 does not document transfers for activities of daily living on 7/12, 7/13, 7/15, 7/16, 7/17, 7/18, 7/19, 7/20, 7/21 or 7/23 of 2021. R1's Documentation Survey Report dated July 2021 does not document R1 having fluid intake on 7/9, 7/12, 7/13, 7/14, 7/15, 7/16, 7/17, 7/18, 7/19, 7/20, 7/21, 7/22, 7/23 and 7/28 of 2021. On 8/9/21 at 12:11 PM V5 Certified Nursing Assistant stated, " When R1 got here R1 was a one assist with a walker. He seemed pretty with it at first but became more and more confused. I found the sore on his bottom and told V9 Facility Wound Nurse. It was black and quarter sized." On 8/9/21 at 12:48 PM V6 Certified Nursing Assistant stated, "R1 obviously wasn't turned every two hours all of the time to get that kind of wound. It was black and a little bigger than a quarter." On 8/10/21 at 9:55AM, V9 Facility Wound Nurse stated, "I feel like with R1, it was a complete lack of attentiveness. If they didn't reposition him, change him and do skin checks then R1's wound was preventable". On 8/10/21 at 4:46PM V16 Nurse Practitioner stated, "When I saw R1 in the facility, I was told that he was eating and drinking ok. When I saw him upon readmission to the hospital, R1 was dehydrated and had clearly lost weight." The	S9999		

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S9999	Continued From page 6 pressure ulcer that he developed in the facility was entirely preventable." R1 was not seen by a Dietician during this stay. On 8/11/21 at 8:45AM V10 Facility Wound Physician stated if a resident wasn't turned or bathed the tissue would not have been observed and that would contribute to the ulcer formation. Observations of the tissue would allow for considerations such as mattress type, normal or altered sensation, nourishment, or malnourishment. Without these observations, it could unfortunately contribute to a deep tissue injury like the one R1 acquired and why R1 required such a large amount of necrotic tissue removed. On 8/12/21 at 10:06 AM V22 Hospital Wound Nurse Practitioner stated, "I saw R1 on 7/29/21 with an unstageable pressure sore on the coccyx. If R1 wasn't changed, turned, or bathed, then a pressure sore was inevitable. I measured it at 4 centimeters long by 4 centimeters deep by 1.5 centimeters deep. It was nearly a circle, covered with slough and necrotic tissue." B. Based on observation, interview, and record review, the facility failed to notify and implement interventions to prevent the development and worsening of pressure ulcers in two R2, R3 of three residents reviewed for pressure ulcers. Findings include: The Facility Wound and Ulcer Policy and Procedure revised dated 1/10/18 documents, "When a resident is found to have a wound a licensed nurse will complete ulcer, either on admission or during their stay the following: care interventions for staff involved in the resident's	S9999		

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S9999	Continued From page 7 care are communicated via the resident care plan. Treatment continues per the physician orders until the wound and or ulcer is healed." R2's skin assessment dated 7/20/21 documents R2 at risk for skin alteration. R2's initial wound assessment dated 7/27/21 documents, "Right heel deep tissue injury acquired in the facility. Unstageable size 3 centimeters x 2 centimeters with no odor or drainage." On 8/3/21 the weekly pressure ulcer report documents the wound as unchanged. On 8/10/21 at 1:30PM, V9 Facility Wound Nurse changed the right heel dressing and the wound appeared circular, nickel sized and a deep purple color. V9 Facility Wound Nurse stated, "It was just a scab; now it is boggy and a deep tissue injury that is worse, you can tell from the color." R2's order dated 7/23/21 documents Heel Protectors to be worn at all times and heels to be floated while in bed. R2's care plan target date 10/30/21 does not document pressure relieving device use for R2's heels. On 8/9/21 at 2:40PM, R2 was sitting in a wheelchair next to the nurse's station with heels resting on the foot pedals. No heel protectors were on R2's feet. On 8/9/21 at 3:10PM, R2 continued sitting in a wheelchair next to the nurse's station without heel protectors on R2's heels. On 8/9/21 at 3:12PM, V11 Registered Nurse stated, "R2 has a pressure wound from resting R2's heels on hard surfaces. I don't know if R2 has an order for heel protectors (padded heel protectors)."	S9999		

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S9999	Continued From page 8 On 8/10/21 at 10:00AM, R2 was sitting in the activity room without heel protectors on properly, allowing R2's heels to rest on the wheelchair foot pedal. On 8/16/21 at 3:30 PM, V9 Facility Wound Nurse stated, "R2 should have heel protectors on at all times. The pressure makes the wound worse and it shouldn't happen." On 8/10/21 at 9:45AM, V9 Wound Nurse changed R3's sacral dressing, found a new area on the right medial thigh. At 9:50AM V9, Facility Wound Nurse stated, R3's catheter leaked a couple of times last week and I think the leaking may have caused this new breakdown." R3's progress note dated 7/27/21 documents R3's catheter had come out and "bulb" was found in R3's bed. R3's progress note dated 8/3/21 documents R3's catheter leaking, there was no physician notification. R3's progress note dated 8/10/21 documents R3 at high risk for skin breakdown. R3's wound documentation sheet dated 8/10/21 documents facility acquired wound found on 8/10/21 4.2 centimeters by 3.1 centimeters by 0.1 centimeters in size, on right medial thigh with scant serous drainage, and granulating tissue. On 8/16/21 at 3:25PM, V2 Director of Nursing stated, "I was told the catheter was leaking again last night. They did not notify the physician." On 8/16/21 at 3:30PM, V8 Assistant Director of Nursing (ADON) stated that V8 ADON had instructed the nursing staff to contact the doctor about the persistent leakage of urine, and skin damage.	S9999		

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S9999	Continued From page 9 The Facility Policy Wound and Ulcer Policy and Procedure revised date 10/1/2018 documents, "All residents will be assessed to determine the degree of risk of developing a pressure ulcer using the (Skin Risk Assessment). The resident will be assessed upon admission, once a week for four weeks, and monthly thereafter." The facility policy revised date 10/1/2018 documents, "Moderate Risk Protocol and High-Risk Protocol include daily skin checks completed by direct care staff. The Facility Wound and Ulcer Policy and Procedure revised date 1/10/18 documents "Approaches will be placed in the resident care plan. Changes in condition including activity level, mental status, mobility, nutritional status, incontinence are promptly reported." The Facility Wound and Ulcer Policy and Procedure revised dated 1/10/18 documents, Changes in condition including incontinence are properly reported. " B"	S9999		