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 08/18/2022

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 Investigation of Facility Reported Incident of 7/5/22/IL148605	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1010h) 300.1010i) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including,	S9999	**Attachment A** **Statement of Licensure Violations**	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

i) At the time of an accident or injury, immediate treatment shall be provided by personnel trained in first aid procedures.

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 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

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and assistance to prevent accidents.

These Requirements were not met evidenced by:

Based on interview and record review the facility failed to provide supervision for one of three residents (R2) reviewed for falls in the sample of three by leaving R2 on the toilet unsupervised. This failure resulted in R2 falling and received a life-threatening head injury, large subdural hematoma, which caused R2's death.

Findings include:

The Physician Order Sheet (POS) dated July 2022 documents the following diagnoses for R2: Hypothyroidism, Paroxysmal Atrial Fibrillation, Chronic Obstructive Pulmonary Disease, Other Abnormalities of gait and mobility, Unsteadiness on feet and generalized Muscle Weakness. The same POS documents R2 receives the blood thinner medication Eliquis (Apixaban) tablet 2.5 milligrams 1 tablet by mouth two times a day for A-fib (Atrial Fibrillation).

The MDS (Minimum Data Set) assessment dated 7/3/22 documents R2 is cognitively impaired and requires staff assistance of one with all tasks of daily living. The same MDS documents R2 is not steady during transition and walking and must have staff with her to stabilize while toileting. The MDS documents R2 requires the use of wheelchair or a walker.

R2's admission fall assessment dated 6/27/22 documents R2 is at high risk for falls. The post fall assessments dated 7/1/22, 7/4/22 and 7/6/22 also document R2 is high risk for falls.

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R2's fall investigation report dated 7/1/22 at 10:15 PM, documents R2 was walking back from the bathroom with V10 CNA (Certified Nurse Aide) and R2's legs became weak and V10 walking with her lowered R2 to the floor.
R2's Progress Notes dated 7/1/22 at 10:15 PM, written V9 RN (Registered Nurse) documents "CNA (V10) was walking to bathroom and (R2's) legs became weak and (V10) lowered her to the floor into sitting position. No pain or injury noted mechanical lifted. Bed was placed in low position, instructed to ring for assistance and not to get up by self."

The Fall Investigation Report dated 7/1/22 documents "Interventions decided by the IDT (Interdisciplinary team) were to use wheelchair for long distances."

R2's facility report titled "Falls Details Report--Occ#1040987" dated 7/1/22 documents "NO" under the section titled "Independent for toileting."

R2's facility Fall Investigation Report dated 7/4/22 at 6:00 PM, documents R2 was found on the floor in front of R2's bed lying on her right side and with the walker on top of her legs. The Fall Investigation Report documents V11, CNA was the staff member who found R2. The Investigation Report documents R2 stated "I was just getting up to go back to bathroom."

Progress notes for R2 dated 7/4/22 at 6:00 PM, written by V9 at 8:29 PM document "R2 was laying on right side in front of bed when (V11) entered, with walker over (R2's) legs. No pain with Range of Motion (ROM) no injury noted at this time. Mechanical lift to bed, neuro (neurological) checks started, bed in low position

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with every 15 minutes rounders continuing."

Progress notes dated 7/5/22 at 1:59 PM, document "Intervention decided by the IDT team was 15 minute rounds to be done for (R2)."

The facility report titled "Fall Details Report--Occ #1041437" dated 7/4/22 documents "NO" under the section titled "Independent for toileting."

The facility's report titled "Report to Illinois Department of Public Health " dated 7/6/22 reports "(R2) was found laying across her bed, no clothes on and the walker turned over on 7/5/22 at 6 PM. It was noted (R2) had a yellowing bruise to the right side of her face from (R2's) fall that occurred prior to admission. On 7/6/22 at 6:40 AM the facility staff noted a purple bruise to R2's right forehead, eye and cheek. The Physician and POA (Power of Attorney) were both notified and an order for (R2) to be sent to Emergency Department was written."

R2's care plan dated 7/5/22 has the interventions in place from the two falls on 7/1/22 and 7/4/22 and it continues to state to "Ensure correct footwear is on and to ensure (R2's) room is free of obstacles and monitor (R2) for unsteady gait, poor balance, poor posture, dizziness and fatigue. Instruct and remind (R2) to use assistive devices to promote safety."

On 8/4/22 at 4:50 PM, V3 CNA stated (on 7/5/22 at 6:00 PM) V3 was getting ready to go to R2's room to get R2 ready for bed. V3 stated V8 unknown CNA came out of R2's room and told V3 that R2 was on the toilet with clothes on. V3 stated that is when she went into R2's room and found R2 on the bed, undressed and lying across her bed sideways with R2 responding to V3's

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S9999	Continued From page 5 questions and the walker turned over on the floor. V3 stated she cleaned R2 up and positioned her correctly in the bed and notified the nurse about the condition she found R2 in. V9 Registered Nurse documents in the progress notes for R2 on 7/6/22 at 4:30 AM, "found laying across bed after taking self back to bed from bathroom (on 7/5/22 at 6:00 PM), right bruising of eye and forehead continues. Ice pack applied and reinstructed not to get up without help. c/o (complain of) foley (indwelling urinary catheter) and having to pee, showed foley and urine in bag to resident at this time again. Continue to monitor for changes in condition. Neuro checks continue at this time." R2's Progress note dated 7/6/22 at 6:40 AM, documented by V11, RN states "CNAs were getting resident out of bed to get dressed for am et (and) noted bruising to right forehead, eye, et cheek. CNA's alerted RN et (and) RN immediately assessed resident et noted a 10.5 cm (centimeter) X 12 bruise to right forehead, right eye, et right cheek. Right eyelid with purple bruising et swelling. Neurochecks initiated et remain @ (at) resident's baseline. VSS (vital signs stable). Resident stated she fell last night. Resident verbalizing to staff et able to answer questions et denies pain other than to right side of face. Resident transferred to toilet per staff et then assisted into w/c (wheelchair) et brought to nurse's station for close monitoring. Will contact MD (Medical Doctor)." R2's Progress Note dated 7/6/22 at 6:55 AM, documents R2 was assessed by the nurse and V7, Physician was at the facility and saw R2 and immediately told the nurse to send R2 to the Emergency Room for evaluation.	S9999		

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R2's Computed Tomography report dated 7/6/22 at 9:09 AM, documents "Large right subdural hematoma, acute, measuring up to 22 centimeters in thickness. Continues to document Moderate bilateral frontal subarachnoid hemorrhages."

Hospital Records dated 7/6/22 document R2 was transferred to another hospital.

R2's Hospital Discharge Summary dated 7/13/22 at 4:52 PM, documents R2 was admitted to the hospital on 7/6/22 and expired on 7/13/22. The Discharge Summary Documents R2's cause of death as Cardiorespiratory Arrest, Acute Subdural Hematoma and that R2's Admission Diagnoses were Mechanical fall and Acute Subdural Hematoma. The Discharge Summary documents R2's Final Diagnosis and diagnosis during hospitalization as Mechanical fall with large right hemisphere acute subdural with subfalcine herniation to the left and right uncal herniation, while on anticoagulant for history of Paroxysmal Atrial Fibrillation.
On 8/10/22 at 3:24 PM V11, RN stated "The CNA's called me to (R2's) room and they said her face was black and blue." V11 stated "(R2) was oriented to name and place and she told me she fell and (V3) picked her up." V11 stated "(V7), Physician was here and gave an order to send her to ER (Hospital Emergency Room) immediately, so I did."

On 8/4/22 at 3:05 PM, V2 Director of Nurses stated, "Yes I was the one who did the interview with the staff for the investigation of R2's fall on 7/5/22." V2 stated V2 believed V3's report that an unknown CNA (V8) left R2 on the toilet. V2 stated that at the time of the fall, R2 would not

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have been safe by herself. V2 stated "I would not expect (R2) to be able to get from the toilet to her bed on her own."

On 8/5/22 at 10 AM, V7 Physician stated "Yes the fall subdural hematoma is the reason the resident (R2) died. I cannot say if (R2) was strong enough to walk back from the toilet to the bed because I had not seen her for a long time, that is one of the reasons I was there at the facility when I gave the order to send to (the) Emergency Room. "

On 8/5/22 at 12:26 PM, V12 and V13 Physical Therapy Assistants stated "(R2) was not strong enough to walk by herself. When we walk with her, she is unsteady, and we always make sure our hands are on her gait belt. (R2) also has the issue of leaning over and complaining (R2's) catheter is hurting."

The facility's "Fall Policy" revision date 4/2019 states: "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 to the risk will be addressed and care planned. "

(A)