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 12/16/2022

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 Incident of 11/10/22/IL153967	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 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 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. 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 interview and record review, the facility failed to effectively supervise R1 to prevent a traumatic fall. This failure resulted in R1 falling to the ground on R1's head and sustaining head lacerations, contusions, and a brain bleed requiring emergency hospitalization and treatment. R1 is one of three residents reviewed for falls in the sample of three. Findings include: R1's Face Sheet (12/15/2022) documents R1 admitted to the facility from the hospital on 10/31/2022. The same record documents R1's diagnoses included: Cognitive Impairment,	S9999		

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S9999	Continued From page 2 Unsteadiness on Feet, Abnormal Gait and Mobility, and Muscle Weakness. R1's admission Fall Risk Assessment (10/31/2022) documents R1 is at High Risk for Falling. R1's subsequent Fall Risk Assessments (11/1/2022, 11/8/2022, 11/13/2022) all document R1 remained at High Risk For Falling. R1's admission Minimum Data Set assessment (11/6/2022) documents R1 utilizes a wheelchair for mobility and has impaired balance during transitions and walking. The same record documents R1 is not steady moving from the seated to standing position or during walking and is only able to stabilize with staff assistance. The facility Occurrence Report (undated) documents R1 sustained a fall on 11/1/2022, one day after R1's admission, and additional falls on 11/7/2022 and 11/10/2022. The facility fall investigation (undated) documents on 11/10/2022 facility staff placed R1 in R1's wheelchair in the hallway near the nurse's station due to poor safety awareness and continual attempts to stand up. The same record documents R1 can no longer balance on R1's feet and R1 attempted to stand up and fell to the ground. The facility Post Fall Investigation (11/11/2022) documents prior to R1's 11/10/2022 fall "Resident (R1) was sitting in w/c (wheelchair) up at nurse's station for visual observation." The same record documents "Resident alone or unattended (at the time of the fall)" and the resident stated "get up" just prior to the fall. On 12/15/2022 at 2:59PM, V4 (Physical Therapy	S9999		

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S9999	Continued From page 3 Assistant) reported R1 had been restless on the day of R1's above fall and had frequently attempted to stand up from R1's wheelchair. V4 reported being in the nearby therapy room at the time of R1's fall and only being able to see R1's head through the therapy room window separating the therapy room from the hallway where R1 was seated in a wheelchair prior to the fall. V4 recalled looking through the window and seeing R1's head rise and then fall abruptly. V4 reported exiting the therapy room into the hallway where R1 was on the ground and being the first staff present to assist R1 after the fall, with no other staff around. V4 reported the nurse on duty, V5, was not at the adjacent nurses's station at the time of R1's fall to the ground and R1 was confused and moaning after the fall. V4 reported being unaware if any facility staff had been assigned to supervise R1 at the time of the fall. On 12/15/2022 at 2:30 PM, V3 (Certified Nurse Aide) reported being in an office nearby the nurse's station and hearing R1 fall to the ground, and when V3 went into the hallway to check on R1, V4 was the only staff present. On 12/16/2022 at 10:40 AM, V3 reported R1 had not verbalized anything prior to R1's fall on 11/10/2022. V3 reported R1's fall may have been preventable had facility staff been present with R1 at the time of R1's fall. On 12/15/2022 at 3:23 PM, V5 (Registered Nurse) reported R1 had been placed at the nurse station on 11/10/2022 for increased supervision due to attempting to get out of her chair. V5 reported returning from a lunch break, and when V5 entered the nursing unit, R1 had already fallen and facility staff were assisting R1. V5 reported not being sure if any facility staff were supervising	S9999		

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S9999	Continued From page 4 R1 at the time of the fall. R1's 11/10/2022 Progress Notes document R1 fell from R1's wheelchair in front of the nurse's station and fell onto R1's left side. The same record documents R1 was crying in pain when moved and a gash and hematoma (bruise) were forming to R1's temple. R1's Emergency Department report (11/11/2022) documents R1 sustained a brain bleed falling from R1's wheelchair to the floor in the facility on 11/10/2022. The same record documents R1 required further evaluation at a higher care level and was transferred to the trauma service at another hospital. On 12/16/2022 at 12:39 PM, V6 (R1's medical provider) reported R1 was redirectable at the time of R1's fall and stated "I can see that (the facility should have provided R1 maximum supervision instead of leaving R1 unsupervised in R1's wheelchair in the hallway on 11/10/2022)." (A)	S9999		