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 03/27/2023

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 Complaint# 2362205/IL157613	S 000		
S9999	Final Observations Statement of Licensue Violations	S9999		
	300.1210b) 300.1210c) 300.1210d)6) 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		Attachment A Statement of Licensure Violations	

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 03/27/2023

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
S9999	Continued From page 1 and assistance to prevent accidents. These requirements were not met as evidenced by: Based on interview and record review the facility failed to provide assistance with ambulation and ensure appropriate placement of non-skid strips to prevent a fall for one of three residents (R5) reviewed for falls on the sample list of six. This failure resulted in R5 falling face first onto the floor, sustaining a laceration to the head which required emergency medical assistance and sustaining a fracture to the nasal bone. Findings include: R5's Emergency Room records dated 1/24/23 at 12:23 PM, documents R5 was seen in the emergency room due to a fall from the standing position and hitting face on the concrete. This record documents R5 has a comminuted (broken into more than two pieces) mildly displaced fracture of the left nasal bone. These records documents R5 received 10 sutures to the forehead laceration. R5's Careplan dated 3/02/21 documents R5's safety awareness is compromised due to a diagnosis of Alzheimer's disease. This care plan includes an intervention to monitor for unsteady gait, poor balance, poor posture, dizziness, and fatigue. R5's Nurse's Note dated 1/24/2023 at 8:30 AM written by V10 Licensed Practical Nurse documents, " (R5) observed falling to floor by CNA (V11, Certified Nurse's Assistant). Resident has no (complaints of) pain at this time. (R5) at baseline A&O x 1(alert and oriented to person).	S9999		

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 03/27/2023

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
S9999	Continued From page 2 No pain with (passive range of motion). Resident able to (move all extremities). Resident VS (vitals signs) stable. No injuries noted. Resident did not hit head." On 3/27/23 at 10:12 AM, V11 stated, R5 didn't feel well that day. V11 stated that morning (1/24/23) after breakfast she toileted R5 and she missed the bed and slid to the floor. On 3/23/23 at 11:21 AM, V10 stated on 1/24/23 at 8:30 AM, R5 had been at breakfast, she is ambulatory without a walker and walked back to room and attempted to get into the bed and slid off the side. V10 stated the intervention put into place was to assist R5 out of bed and with ambulation. That was the intervention I put into place because she was really unsteady and acting tired. The next fall happened at 11:25 AM. R5's Nurse's note dated 1/24/2023 at 12:09 PM written by V10 documents, (R5) observed by CNA (V11) falling to floor from standing position. (R5) noted to have open area on forehead that was bleeding, and bloody nose. Area was cleansed with NS (normal saline) and pressure dressing applied, nose bleed was controlled." This note also documents R5 was sent to the emergency room for an evaluation." On 3/27/23 at 10:12 AM, V11 stated after the first fall on 1/24/23 the new intervention was to assist her with transfers and ambulation. V11 stated she went in there to get her up and she stood up fine. V11 stated when V11 was turning to walk out of the room R5 fell straight on her face. V11 stated she turned to walk with me and she fell straight down. V11 stated she fell right in front of her bed. On 3/27/23 at 1:19 PM, V3 Assistant Director of	S9999		

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 03/27/2023

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
S9999	Continued From page 3 Nursing stated she investigated R5's fall. When asked about the root cause of the fall, V3 stated when she reenacted the fall by sitting on the edge of the bed. V3 noticed that her left foot was on the nonskid strip that was on the floor but her right foot was not. V3 stated the strips in front of the bed needed to be longer so that both of R5's feet would touch the non skid strips. V3 stated she also found out that V11 had went in to get R5 to take her to lunch. V3 stated V11 told her that the fall happened when she turned to leave and told R5 that it was time for dinner. V3 stated V11 told me that her back was to her when she fell. V3 stated she fell face first onto the floor. (B)	S9999		