

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>145772</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>03/05/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>ODD FELLOW-REBEKAH HOME</b>		STREET ADDRESS, CITY, STATE, ZIP <b>201 LAFAYETTE AVENUE EAST MATTOON, IL 61938</b>	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
F 0689  <b>Level of harm</b> - Minimal harm or potential for actual harm  <b>Residents Affected</b> - Few	<p><b>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</b> <b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b></p> <p>Based on record review, observation and interview the facility failed to ensure R2's immobilized leg was not secured to her wheelchair, putting her at increased risk for falls. R2 is one of three residents reviewed for incidents and accidents. Findings include: The Face Sheet for R2 documents [DIAGNOSES REDACTED]. R2's Physician order [REDACTED]. R2's Care Plan documents a Brief Interview for Mental Status (BIMS) score as a possible 3 out of 15 total points (severely cognitively impaired). This same care plan documents four separate falls dated 1/1/20, 1/25/20, 1/25/20 and 2/3/20. R2 incurred a left [MEDICAL CONDITION] as a result of a fall on 1/1/20, a left distal femur fracture as a result of a 2/3/20 fall, and a worsening displacement of the previous left distal femur fracture noted on 2/19/20. This same Care Plan documents to immobilize R2's fracture site as ordered and use immobilizer except when bathing initiated on [DATE]. R2's Minimum Data Set ((MDS) dated [DATE] documents R2 requiring extensive assistance of one person for dressing, locomotion on and off unit and personal hygiene. R2's Fall Scale dated 1/5/2020 documents a score of 75 points (high risk for falling). Physical Therapy Recertification and Updated Plan of Treatment dated 2/2/20 documents R2 currently able to ambulate 60-75 feet with minimal assist during therapy session. On 3/4/2020 at 11:40 AM R2 was sitting in the wheelchair outside dining area with no staff present. R2's safety waist belt was unfastened and tucked under the cushion R2 was sitting on. R2's left leg was elevated, resting on the elevated foot pedal. A yellow gait belt was wrapped around R2's left leg and left foot pedal just below R2's knee and snugly secured. R2 was attempting to push another resident in wheelchair in front of R2. R2 attempted and was unable to remove the gait belt that secured R2's left leg to wheelchair pedal. After the gait belt was removed from R2's left lower leg, indentations remained approximately one inch in depth where the gait belt had been placed. On 3/4/2020 at 11:50 AM V7, Physical Therapy Assistant stated V7 instructed floor staff to use a long blue elastic wrap with (hook and loop fastener) edges to wrap around R2's left leg and wheelchair pedal. V7 stated I can see now how dangerous that could be. V7 stated R2 is able to stand and does stand in therapy sessions. V7 also stated using a gait belt to secure R2's leg to wheelchair pedal could result in injury or harm to R2. On 3/5/2020 at 9:50 AM V8, Orthopedic Medical Assistant, stated the facility should follow physician orders [REDACTED]. V8 stated tying R2's leg to wheelchair pedal R2 could be cause for possible harm and injury to R2. V8 stated V10 did not recommend this type of immobilization of leg for any resident. On 3/5/2020 at 1:30 PM V2 Director of Nurses (DON) stated a gait belt should never be used to restrain a resident. V2 stated R2 could be seriously hurt if R2 attempted to stand or get out of wheelchair. V2 stated staff should follow fall precautions to prevent injuring a resident. On 3/5/2020 at 2:30 PM V1, Administrator confirmed staff should not use a gait belt to tie a resident leg to wheelchair and that this could cause injury to resident.</p>		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.