STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145772	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Odd Fellow-Rebekah Home	201 Lafayette Avenue East Mattoon, IL 61938

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on interview and record review the facility failed to notify a residents Physician timely for the residents fall with injury. This failure affects one (R171) out of five residents reviewed for falls in a sample list of 75 residents. Findings include: R171's undated Face Sheet documents medical diagnoses as Vascular Dementia, Unsteadiness on Feet, Muscle Wasting and Atrophy, Abnormalities of Gait and Mobility, Obstructive and Reflux Uropathy, Presence of Urogenital Implants, Venous Thrombosis and Embolism, Transient Ischemic Attack (TIA), Cerebral Infarction, Long Term Use of Anticoagulants and Anxiety Disorder. R171's Minimum Data Set (MDS) dated [DATE] documents R171 as severely cognitively impaired. This same MDS documents R171 as requiring maximum assistance with toileting and moderate assistance with bathing, dressing, personal hygiene and bed mobility. R171's Careplan intervention dated 2/23/24 documents (R171) may transfer and ambulate with one assist, assistive device and gait belt. R171's Fall Risk assessment dated [DATE] documents R171 as a high fall risk. R171's Physician Order Sheet (POS) dated September 2024 documents a physician order starting 3/19/24 for Aspirin 81 milligrams (mg) daily for Chronic Atherosclerosis Disease. This same POS documents Rivaroxaban 10 mg daily starting 7/3/24 for blood clot prevention. This same POS documents a physician order starting 9/16/24 to cleanse R171's Left Eye Laceration, apply Steri-Strips and monitor twice daily until healed. This same POS documents a physician order starting 9/18/24 to monitor bruising to area behind Left ear and into hairline until resolved twice daily. R171's Nurse Progress Note dated 9/15/24 at 1:19 PM documents (R171) observed on floor with laceration above Left eye with small Hematoma. Ice applied and steri strips applied. Neurological (neuros) assessments initiated, neuros within normal limits (WNL) baseline for (R171), range of motion (ROM) WNL, (R171) able to stand and walk after being assist to chair via total body mechanical lift. R171's Fall Investigation dated 9/15/24 for R171's fall on 9/15/24 at 12:45 PM documents V22 Physician was notified at 1:05 AM (9/16/24). (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R171's Hospital Record dated 9/15/24 documents R171 was seen at the emergency roiagnom on [DATE] after another(the same day) unwitnessed fall at the facility. This same hospital record documents R171's diagnosis as Closed Head Injury. On 10/8/24 at 2:00 PM, V2 Director of Nurses (DON) stated the facility does not have a policy that states when to notify the physician after a resident falls, only that the staff should notify the physician. V2 DON stated the staff should notify the physician after a fall with a head injury. On 10/8/24 at 3:00 PM, V22 Physician/Medical Director stated V22 did not receive notification of R171's fall on 9/15/24 at 12:45 PM until 9/16/24. V22 stated any resident who has had a fall with a head injury and is on anticoagulants should automatically be sent to the emergency room for evaluation. V22 stated the facility should have called V22 to notify of R171's fall on 9/15/24 at 12:45 PM. V22 stated R171 fell again at 7:00 PM on 9/15/24 when R171 was sent to the emergency room and diagnosed with a closed head injury. V22 stated We really cannot determine which of (R171's) falls caused the closed head injury because the two falls were so close together and (R171) was not sent to the emergency room after the first fall when she hit her head but it would be sensible to say that it was the one when (R171) had a head injury. I would have instructed them (facility) to send (R171) to the emergency room after her first fall. Unfortunately, we will never know.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on interview and record review the facility failed to complete a recapitulation of stay for one (R118) resident out of one resident reviewed for discharge in a sample list of 75 residents. Findings include: The facility policy titled Discharge Record Processing revised 10/25/2022 documents a Discharge Summary is to be completed and signed by the Physician. All discharged records should be completed within 30 days of discharge. R118's undated Face Sheet documents R118 admitted to the facility on [DATE] and discharged on [DATE]. R118's Minimum Data Set (MDS) dated [DATE] documents R118 as moderately cognitively impaired. R118's Electronic Medical Record (EMR) does not include documentation of a recapitulation of stay. On 10/4/24 at 11:15 AM, V2 Director of Nurses (DON) stated the recapitulation of stay was not completed for R118. V2 DON stated anytime a resident discharges there is a specific form that is completed which includes the discharge summary/recapitulation of stay and this was not completed for R118.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 31642 Based on observation, interview and record review the facility failed to apply physician ordered compression stocking for one of one residents (R81) reviewed for edema on the sample list of 75. Findings include: R81's diagnoses sheet dated 10/04/24 documents the following diagnoses: Bilateral Primary Osteoarthritis of the Knee, Type II Diabetes Mellitus Without Complications, Acute Embolism and Thrombosis of Unspecified Deep Veins of Left Lower Extremity. R81's Physician Order Summary Report dated 10/04/24 documents the following: Apply bilateral (name brand compression) hose in the morning and remove at bedtime. On 10/4/24 at 10:47 am, R81 was seated in a wheelchair bedside with non-skid socks on that had been slit at each heel. R81's feet were visibly swollen. R81 stated she was agitated because an unidentified Certified Nursing Assistant (CNA) put non-skid socks on R81, instead of R81's compression hose. On 10/4/24 at 11:03 am, V25, Licensed Practical Nurse confirmed R81 does not have R81's compression hose on, as the physician ordered. V25 stated The CNA's are suppose to put them on in bed, as the get her (R81) up in the morning. She should have had them on, hours ago. At this time, R81 then stated to V25, I have three new pair (compression hose) in the top drawer of my dresser. They slapped these socks on me (non-skid), that have to be split at the back to fit my swollen feet. I tell them I need my (name brand compression) hose on. They say they will come back to put them on. Sometimes, that doesn't happen, as you can see. My leg swelling gets worse and worse if I don't wear these (name brand compression) hose. There have been several days where I go without. They are suppose to be on every day and off every night.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on observation, interview and record review the facility failed to assess and monitor (R10, R18) pressure ulcers and failed to provide (R26) a pressure relief chair cushion. These failures affected three of six resident (R10, R18, R26) reviewed for pressure ulcers on the sample list of 75. Findings include: 1.) R26's Minimum Data Set (MDS) dated [DATE] documents R26's Brief Interview of Mental Status score as 13 out of a possible 15, indicating no cognitive impairment. The same MDS documents Skin and Ulcer/Injury Treatment check all that apply; The box for pressure reducing device for a chair, is checked. R26's Braden Scale - for Predicting Pressure Ulcer Risk Evaluation dated 9/3/24 documents R26 is at risk for developing pressure ulcers. R26's Physician Order Sheet documents the following treatment orders: 1. Cleanse open fistula area on L (left) hip with wound wash or NS (normal saline), apply collagen to wound bed then apply Calcium Alginate et (sic), cover with Border (bordered) foam. (Do Not apply border gauze), daily. 2. Cleanse area to RLE (right lower extremity) with wound wash or NS. Apply collagen to wound bed et.(sic) cover with border foam. (DO NOT use border gauze), daily. 3. Apply desitin to area on right buttock, two times a day. 4.Apply skin prep to R26 (right) heel, two times a day. 5. May use house barrier cream after each episode of incontinence and PRN (as needed). May keep at bedside. R26's Care Plan updated 10/01/24 documents the following: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I am at risk for impaired skin integrity due to impaired mobility, poor appetite. My open area will heal within 8 (eight) weeks. Assess for signs of complication/infection on my skin such as increased redness, warmth, drainage and edema. Keep area clean, dry and free from irritating substances. Measure, establish parameters and document to evaluate effectiveness of treatment. Monitor intakes, encourage 77-100%. Provide dietician intervention as needed. May use house barrier cream after each episode of incontinence and PRN (as needed). May keep at bedside. Assess my skin per policy. Daily if moderate risk or higher, or if wound present. Weekly on bath day. Protect my skin from scrapes, bumps, pressure, tight fitting clothes. Provide me with a pressure reduction mattress. May use a pressure reduction cushion if use a wheelchair. Remind/assist me to shift my weight/reposition at least every two hours. Ensure pressure reduction on any areas that might be impaired with education/assistance. The same care plan updated 10/1/24 documents the following treatments (Tx) continues (conts). 6/29/24 Tx to area: Left hip. TX as ordered by physician. 7/2/24 Tx conts. 7/9/24 Tx conts. 7/16/24 Tx conts. 7/23/24 Tx conts. 7/30/24 Tx conts. 8/6/24 Tx conts. 8/13/24, Tx conts. 8/20/24 Tx conts. 8/27/24 Tx conts. 9/3/24 Tx conts. 9/10/24 Tx conts. 9/17/24 Tx conts. 9/24/24 Tx conts. Date Initiated: 10/01/2024. On 10/3/24 at 12:07 PM, R26 was seated in her recliner chair eating lunch. There was no cushion in R26's chair. R26 stated There is no cushion in my chair. I wish there was. I sit here a lot. Most of the day. I don't want that sore on my b***(buttock) to open again. On 10/3/24 at 12:12 pm, V14, Certified Nursing Assistant stated, (R26) had a dressing on her left hip and right shin that the nurse took off, I think it was (V25, LPN). CNA's don't do that. If the dressing falls off, we tell the nurse right away. She also had an area above her tailbone, but I did not see a dressing on that today, when I gave her shower. On 10/3/24 at 1:05 pm, V25, Licensed Practical Nurse (LPN) entered R26's room. R26 laid flat on her back in bed. R26's recliner had no pressure relief cushion in the chair. V25, LPN completed R26's right lower leg wound dressing change, left anterior hip fissure wound dressing change, and repositioned R26 to a left side lying position to provide treatment to R26's coccyx. R26's coccyx had nine pencil sized, unopened, red sores with peeling dry shearing skin that spread out in a scattered fashion, over an approximately five inch diameter, deep red scarring on R26's coccyx. V25 LPN stated None of the areas are open now. The scar is from a previous pressure ulcer. (R26) had a coccyx pressure ulcer here (coccyx) we healed out. She has only had shearing areas on her coccyx, for quite awhile. We use the barrier cream to prevent further breakdown. On 10/03/24 at 1:40 pm, V25 LPN completed R26's wound treatments and stated There should probably be a cushion in her recliner to prevent the pressure on her coccyx. The facility policy Wound and Ulcer Policy and Procedure dated 3/28/24 documents the following: It is the policy of this facility to provide nursing standards for assessment, prevention, treatment, and protocols to manage residents at any level of risk for skin breakdown and for wound management. Procedure: All residents will be assessed to determine the degree of risk of developing a pressure ulcer using the Braden Scale- Ulcer Risk Assessment. The resident will be assessed upon admission, once a week for four weeks, quarterly, and any significant change in condition after admission. The same policy documents: When an existing or newly developed pressure ulcer(s) is present, a skin assessment (skin check) will be documented each shift to monitor the individual resident's tolerance to the current repositioning schedule (tissue tolerance) and the facility will re-evaluate the frequency of repositioning if indications of further breakdown occur. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A skin assessment (skin check) will be documented at least daily when a wound (e.g., skin tear, laceration, bruise) is present. The same policy documents: High Risk Protocol: Residents with existing ulcers will be deemed as high risk for impaired skin integrity despite the Braden Risk Assessment Score. Daily skin check- completed by direct care staff. The Skin Observation Report may be used to communicate skin observations or changes to the nurse. Specialty mattresses (low air loss, alternating pressure, etc.) with enhanced pressure reducing/relieving properties may be placed on the resident's bed and chair as indicated. Skin contact surfaces may be padded to protect boney prominence's. 41970 2.) R10's Electronic Medical Record (EMR) documents R10's medical diagnoses as Non ST Elevation Myocardial Infarction, Congestive Heart Failure, Diabetes Mellitus Type II, Unsteady on Feet, Abnormal Gait and Mobility, Dysphagia, Sacral Pressure Ulcer Stage II, Left Ankle Pressure Ulcer Stage II and Muscle Weakness. R10's Minimum Data Set (MDS) dated [DATE] documents R10 as severely cognitively impaired. This same MDS documents R10 requires maximum assistance with toileting, dressing, bed mobility and moderate assistance with personal hygiene and transfers. R10's Physician Order Sheet (POS) dated October 2024 does not document a treatment for R10's Stage II Sacral Pressure Ulcer. R10's Careplan initiated 3/22/2024 does not document a focus area, goal nor interventions for R10's Left Ankle Pressure Ulcer nor R10's Sacral Pressure Ulcer. R10's Nurse Progress Note dated 9/9/24 at 1:42 AM documents During cares this evening it was noted that (R10's) Sacral area needs addressed. Assessed (R10), Stage 2 pressure area, possibly stage 3 to Sacral region, area cleansed, paste applied to area, covered with a sacral border gauze dressing, will notify hospice and make them aware of breakdown. Will note changes accordingly. R10's Electronic Medical Record (EMR) does not document a assessment of R10's Sacral Stage II Pressure Ulcer. On 10/1/24 at 1:35 PM, R10 was laying in bed on her back. R10 was not wearing heel protectors nor did she have her feet floated. On 10/2/24 at 2:20 PM, R10 was laying in bed on her back. R10 was not wearing heel protectors nor did she have her feet floated. On 10/3/24 at 12:05 PM, R10 was laying in bed on her back. R10 was not wearing heel protectors nor did she have her feet floated. 3.) R18's undated Face Sheet documents R18's medical diagnoses as Metabolic Encephalopathy, Diabetes Mellitus Type II, Muscle Wasting and Atrophy, Parkinson's Disease and Chronic Kidney Disease Stage 3. R18's Minimum Data Set (MDS) dated [DATE] documents R18 as moderately cognitively impaired. This same MDS documents R18 requires moderate assistance with toileting, bathing, dressing, personal hygiene, bed mobility and transfers. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R18's Care plan initiated 6/14/24 does not document a focus area, goal nor interventions for R18's Right and Left Buttock wounds. R18's Physician Order Sheet (POS) dated October 2024 does not document a physician order for R18's Right Buttock Stage II Pressure Ulcer. R18's Treatment Administration Record (TAR) dated September documents R18's treatment to her Left Buttock was not completed on 9/28 and 9/29/24. R18's Electronic Medical Record (EMR) does not document an assessment of R18's Right Buttock Stage II Pressure Ulcer. On 10/3/24 at 10:45 AM, V27 Licensed Practical Nurse (LPN) completed R18's Left Buttock Stage II Pressure Ulcer treatment. R18 did not have a dressing in place at the beginning of the dressing change. R18's Left Buttock nickel sized open area had dark red edges and a dark purple periwound. R18's Right Buttock had a nickel sized open area with dark red edges and a dark purple periwound. R18's incontinence brief was soiled with a brown line of bowel movement which laid directly against R18's wounds. V27 LPN did not measure or assess R18's Right Buttock Pressure Ulcer. On 10/3/24 at 11:05 AM, V27 Licensed Practical Nurse (LPN) stated R18 has two open areas on her buttocks. V27 stated (R18) had the Left Buttock Pressure Ulcer and now she has a Right Buttock Pressure Ulcer. I didn't see any orders for (R18's) Right Buttock Pressure Ulcer. On 10/8/24 at 8:45 AM, V29 Licensed Practical Nurse (LPN)/Wound Nurse stated staff should complete a full assessment of all residents with a new wound. V29 stated the nurse should complete an assessment that includes a description of the wound, drainage, odor, pain level and measurements. V29 stated I check the orders to see which residents have a new order for a treatment. That is how I know of any new wounds. If the nurse doesn't enter the order, then I will never know about the wound and not be able to monitor and track it on my reports. The resident should have an assessment, pressure ulcer risk and documentation of the wound as well as notifications are to be made to the Physician and the resident representative. I was not aware of (R10's) wound on her Sacrum until today (10/8/24). I was made aware of (R18's) new Right Buttock Stage II Pressure Ulcer on 10/4/24, but there was not an assessment or any documentation of (R18's) wound. The facility policy titled Wound and Ulcer Policy and Procedure revised 3/28/2024 documents when an existing or newly developed pressure ulcer (s) is present, a skin assessment will be documented each shift to monitor the individual resident's tolerance to the current repositioning schedule (tissue tolerance) and the facility will re-evaluate the frequency of repositioning if indications of further breakdown occur. High risk protocol approaches will be placed in the resident's care plan. When a resident is found to have a wound a licensed nurse will complete either on admission or during their stay, the following: document assessment of the wound/ulcer in the medical record, initiate the treatment protocol appropriate for the status of ulcer. Document ulcer treatment provision on the treatment administration record (TAR). Notify the Physician and Power of Attorney for Healthcare (POAHC) regarding change in the resident's condition. Care interventions for staff involved in the resident's care are communicated via the resident care plan. Assessment of progress toward healing is completed at least weekly and the physician is notified at least monthly of progress toward healing. Treatment continues per the physician orders until the wound and/or ulcer is healed.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on interview and record review the facility failed to develop post fall interventions and treatment for a resident on anticoagulant therapy with head injury (R171), failed to implement careplan interventions for a resident (R171) post fall, failed to complete fall risk assessments and failed to thoroughly investigate falls for a resident (R67). These failure affects two (R171, R67) out of five residents reviewed for falls in a sample list of 75 residents. These failures resulted in R171, who was receiving anticoagulants, falling and sustaining a subdural hematoma. Findings include: The facility policy titled Fall Assessment and Management Policy revised June 2024 documents the facility will 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. A licensed nurse will document for 72 hours after the incident regarding the resident's status and note any changes in the resident's condition. 1.) R171's undated Face Sheet documents R171's medical diagnoses as Dementia, Unsteadiness on Feet, Abnormalities of Gait and Mobility, Long Term Use of Anticoagulants, Osteoporosis without current Pathological Fracture and History of Venous Thrombosis and Embolism. R171's Minimum Data Set (MDS) dated [DATE] documents R171 as severely cognitively impaired. This same MDS documents R171 as requiring maximum assistance with toileting and moderate assistance with bathing, dressing, personal hygiene and bed mobility. R171's Physician Order Sheet (POS) dated September 2024 documents a physician order starting 3/19/24 for Aspirin 81 milligrams (mg) daily for Chronic Atherosclerosis Disease. This same POS documents Rivaroxaban 10 mg daily starting 7/3/24 for blood clot prevention. R171's Careplan intervention dated 2/23/24 documents (R171) may transfer and ambulate with one assist, assistive device and gait belt. R171's Fall Risk assessment dated [DATE] documents R171 as a high fall risk. This same careplan documents a fall intervention dated 9/15/24 to place R171 on a restorative ambulation program. R171's medical record documents R171 fell on ,d+[DATE] at 12:45 PM resulting in a left eye laceration. There was no documentation that the physician was notified of this fall. There were no policies regarding residents on anticoagulant therapy urgent treatment post head injury needs. R171 fell on [DATE] at 7:00 PM, R171 complained of hip pain, R171 was sent to the emergency room (ER) for hip pain. ER documented closed head injury. R171's Electronic Medical Record (EMR) does not document R171's restorative evaluation or program notes. This same EMR does not document R171 as being in the restorative ambulation program nor receiving any assistance for the restorative ambulation program. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R171's Nurse Progress Note dated 9/20/24 at 3:14 PM documents (R171) was observed on the floor in the hallway. (R171) was on her left side. A reopened laceration to her Left Temple was noted. On assessment (R171) was not able to move her left leg due to excruciating pain. (R171) stated I'm going to pass out! Ambulance was called. Emergency Medical Technicians (EMT'S) left with the resident at 3:04 PM. R171's emergency room Progress Notes dated 9/20/24 document R171 was seen in the emergency room after having an unwitnessed fall at facility on 9/20/24. This same progress note documents (R171) has fallen twice in the last week. Today, after falling (R171) became increasingly altered. (R171) is oriented x0 and obtunded. (R171) is obviously unwell. (R171) does not follow commands and is having some occasional sonorous respirations. Spontaneous eye opening, no verbal or motor response. (R171's) head is laid over to the Left, does not track to the Right. R171's Computerized Tomography (CT) of her brain without contrast dated 9/20/24 documents Findings: Large Left Frontal and Temporal mixed density Subdural Hematoma measuring 3.2 centimeters (cm) in maximum diameter. The majority of this hemorrhage appears acute. Considerable mass effect on the underlying brain parenchyma resulting in 1.8 cm of rightward midline shift. Left Frontal Scalp soft tissue swelling. R171's Death Certificate documents R171's date of death as 9/21/24 with a Primary Cause of Death as Subdural Hematoma with an approximate interval between onset and death as one day. On 10/8/24 at 9:05 AM, V36 CNA stated R171 was severely cognitively impaired and had very poor safety awareness. V36 stated I don't know that (R171) was ever on a restorative ambulation program. It never came up in our charting. I worked with (R171) all the time and no one ever said anything about that. (R171) was impulsive and quick. (R171) would be laying down one minute and up the next. (R171) was very unsteady when she walked and needed one person to help her. (R171) was on 15 minute monitoring for months. I had last checked on (R171) 15-20 minutes prior to her falling on 9/20/24. It was awful. I found her in the hallway outside her room. (R171) was bleeding. I sat there with her. (R171) bled all over my pants. I'll never forget that. I felt so bad for (R171) but I don't know what else we could have done besides putting her on a one to one. (R171) needed constant supervision and we (facility) just couldn't keep up with her. At this time V36 CNA also stated, the fifteen minute rounders means the call lights are activated every 15 minutes in the resident's room. V36 CNA stated the rounder lights can be deactivated in the resident room or at the nurses station. V36 stated when the 15 minute rounders go off the staff are supposed to visually see the resident to make sure they are safe. On 10/8/24 at 10:50 AM, V7 Assistant Director of Nurses (ADON)/Restorative Nurse stated restorative programming is completed by the floor CNA assigned to the resident in a program. V7 stated V7 was on leave from 8/2/24-9/29/24 and V42 Restorative CNA was on leave from 9/19/24-10/9/24. V7 stated V7 is not able to find any documentation that R171 was ever evaluated or started on the restorative ambulation program. V7 stated It shouldn't matter if I was gone or not. (R171's) careplan intervention was added for her 9/15/24 fall and was never done. (R171) could have benefited from that program. It may have not prevented her fall on 9/20/24 but we really don't know because (R171) never received the services. (continued on next page)

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	145772	A. Building B. Wing	10/08/2024

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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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/8/24 at 12:30 PM, V2 Director of Nurses (DON) stated the facility has a system that activates a call light in the residents room every 15 minutes for any resident placed on 15 minute rounders. V2 stated there is a button at the nurses station and also in the resident rooms to deactivate the 15 minute rounders. V2 stated the staff are supposed to visualize the resident every 15 minutes and then deactivate the call system. V2 stated the call system will automatically come back on every 15 minutes. V2 DON stated Normally, I am able to pull a report of what exact time the 15 minute reminder was activated and deactivated but our system is down today and I am not able to provide any documentation that (R171) was being checked on every 15 minutes. V2 DON stated the facility does not have a policy on restorative programming or 15 minute rounders/call light policy. On 10/8/24 at 3:00 PM, V22 Physician/Medical Director stated R171 should have been sent to the emergency room after her 9/15/24 12:45 PM fall due to being severely cognitively impaired, having a fall with a head injury and on anticoagulants (ASA, Rivaroxaban). V22 stated after R171's falls on 9/15, she should have been on 'very close' monitoring. V22 stated (R171) did not have a strength deficit. I don't know why they (facility) would have placed her on a restorative ambulation program. (R171) was too ambitious with movements. Along with her cognitive impairments, (R171) could not foresee any dangers due to her poor cognition. (R171) relied solely on the staff to ensure her safety. I don't normally recommend the personal alarms or one to one's (continual observation) but (R171) would have been a great candidate due to her poor awareness of instability. (R171's) falls were missed opportunities resulting in her major injuries. 31642 2.) R67's diagnoses sheet dated 7/9/24 documents the following diagnoses: Muscle Weakness (Generalized) Repeated Falls, Spinal Stenosis, Cervical Region, Non-Surgical Orthopedic/Musculoskeletal, Spinal Stenosis, Lumbar Region Without Neurogenic, Claudication, Radiculopathy, Cervical Region, Non-Surgical Orthopedic/Musculoskeletal, Muscle Wasting Andatrophy, Not Otherwise Classified, Unspecified Site, Personal History Of Transient Ischemic Attack, and Cerebral Infarction Without Residual Effect Deficits. R67's Unwitnessed Fall investigation dated 8/25/24 at 5:14 pm documents the following (the same as the corresponding nurses note): Resident told CNA this morning while getting him up that he was just on the floor and 2 (two) girls came in and picked him up and put him back into bed. Resident was assessed no injury's were noted, no pain on range of motion, neuros (neurological assessment) were started because self reported fall. There are no documented interviews by V2, Director of Nursing, of R67, any other residents that may have had knowledge of the fall, or any CNA's or Nurses working that morning. There is no post-fall 8/25/24 risk assessment as policy directs. R67's Unwitnessed Fall investigation dated 9/21/24 at 3:37 am documents the following (the same as the corresponding nurses note):Resident was yelling, help me. When nurse walked into resident's room resident was observed sitting on knees next to bed. Resident's top half of body was still in bed and the lower half of body hanging out of the bed. Nurse notified CNA (unidentified) to help assist resident back into bed per 2 (two) assist (unidentified). CNA assisted resident to be cleaned up. Urine was observed on the floor. Resident Description: Resident stated he was trying to roll to his other side. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	There are no documented interviews by V2, Director of Nursing, of R67, any other residents that may have had knowledge of the fall, or any CNA's or Nurses working that morning. There is no post- fall 9/21/24 risk assessment as policy directs. R67's Unwitnessed Fall investigation dated 9/22/24 at 11:20 am documents the following (the same as the corresponding nurses note): Patient found sitting on floor on knees next to bed facing head of bed. CNA stated pt. head was caught on bedside rail. Resident Description: Patient stated he was unsure how he got on floor. There are no documented interviews by V2, Director of Nursing, of R67, any other residents that may have had knowledge of the fall, or any CNA's or Nurses working that morning. On 10/8/24 at 11:25 am, V2, Director of Nursing (DON) reviewed R67's fall investigations 8/25/24, 9/21/24 and 9/22/24 and stated he did not interview anyone, does not know the last time that R67 was seen by staff and only has the details he obtained from R67's nurses notes that document R67 slid out of bed on each of those falls. V2, DON stated he is working on a better electronic medical record system to complete a more thorough fall investigation. At this time I have not implemented a new system to ensure the investigations are completed thoroughly. V2, DON also stated he does not have fall risk assessment for R67's falls on 8/25/24 or 9/21/24. He expects the nurses to complete them when a fall occurs.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32172 Based on interview and record review the facility failed to maintain a resident's nutritional status and prevent significant weight loss by failing to implement nutritional supplements recommended by the dietician, and failing to notify the physician and dietician when significant weight loss continued. This failure resulted in R36 continuing to lose a significant amount of weight over one months time. This failure affected one of two residents (R36) reviewed for nutrition on the sample list of 75. Findings Include: The facility's Weight Management Policy and Procedure dated 2023 documents all residents will be monitored for significant weight changes to assure maintenance of acceptable parameters of body weight. Any resident with a significant weight change will be referred to the dietitian for assessment of the resident's condition. The dietician will implement any necessary clinical interventions or make recommendations regarding diet and supplementation to the physician. The physician will be notified of any significant weight change and be made aware of any recommendations made by the dietitian. R36's Medical Diagnoses sheet dated October 2024 documents R36 is diagnosed with Protein Calorie Malnutrition and Muscle Wasting and Atrophy. R36's Physician Order Sheet dated October 2024 documents R36 is prescribed a regular diet with thin liquids. R36's Care Plan dated 8/9/24 documents R36 is at risk for altered nutrition. Interventions include to provide supplements as ordered, monitor intakes, report weight changes to physician, and refer to dietician as needed. R36's Weights Record document on 8/9/24 R36's weight upon admission was 130.6 pounds. On 8/28/24 R36's weight was 120.1 pounds. R36's Dietician assessment dated [DATE] documents R36 was admitted on [DATE] and weighed 129.3 pounds on 8/12/24. The same assessment documented R36 had a weight loss of 12 pounds or nine percent of her weight over the last thirty days according to (pre-admission) hospital and facility records. A recommendation was made for R36 to begin to receive 60 cubic centimeters of a liquid nutritional supplement three times per day in order to prevent further weight loss. There is no documentation in R36's medical record that the recommended nutritional supplement was implemented or that the physician was ever notified of R36's continued weight loss of 9.2 pounds. On 10/4/24 at 12:57 PM, V2 Director of Nurses (DON) confirmed R36's recommended nutritional supplements were not implemented and R36 continued to lose weight. R36 had a significant weight loss of 10.5 pounds (7.69%) from admission on 8/9/24 to 8/28/24. V2 DON confirmed the facility should have notified the physician of and then implemented the nutritional supplement recommendation and monitored R36's weight closely. Staff should have notified the physician of R36's continued weight loss which ended up being significant. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 10/4/24 at 1:49 PM, V32 Registered Dietician confirmed she assessed R36 on 8/13/24 for nutritional risk and significant weight loss prior to admission. In order to assist in further weight loss, V32 recommended R36 be given a nutritional supplement three times a day. V32 confirmed her recommendation should have been sent to the physician and added to R36's plan of care. V32 confirmed if the nutritional supplement would have been implemented, potentially R36's weight loss could have been lessened.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on observation, interview and record review the facility failed to implement care plan interventions and failed to label enteral feeding bottles for two (R84, R321) out of two residents reviewed for Gastrostomy tubes (G-tube) in a sample list of 75 residents. Findings include: The facility policy titled Enteral/Tube Feeding Policy revised 2/26/2015 documents feeding solutions will be stored at room temperature until opened at which the feeding will be labeled to include the date and time the formula was opened. To prevent retrograde contamination from resident into a feeding bag container, keep the head of the bed elevated 30-45 degrees during feeding and for 30-60 minutes after feeding. 1.) R84's Minimum Data Set (MDS) dated [DATE] documents R84 as cognitively intact. This same MDS documents R84 requires maximum assistance with toileting, bathing, dressing and moderate assistance with personal hygiene and bed mobility. R84's Care plan intervention dated 11/3/22 documents R84's head of bed should be elevated 30 degrees due to risk of aspiration. R84's Physician Order Sheet (POS) dated October 2024 documents a physician order starting 6/10/24 for Jevity 1.2 Calorie/Fiber to run at 85 milliliters (ml) per hour in the afternoon, to run until 1000 ml completed. On 10/1/24 at 10:50 AM, R84's Jevity 1.2 calorie feeding was running through an automated pump. R84 was laying down in her bed with the head of bed flat. R84's enteral feeding bottle had a preprinted label that was not filled in. On 10/2/24 at 8:45 AM, R84's Jevity 1.2 calorie was running at 85 milliliters (ml) per hour. R84's Jevity 1.2 calorie bottle had 10/1 written on the label with no other information documented. R84 had a bag of water connected to R84's feeding pump with no label. R84 was laying down in her bed with head of bed flat as R84's Jevity 1.2 calorie feeding was running. On 10/2/24 at 10:55 AM, R84's Jevity 1.2 calorie feeding was running through an automated pump. R84 was laying down in her bed with the head of bed flat. On 10/2/24 at 8:47 AM, V8 Licensed Practical Nurse (LPN) stated R84's Jevity feeding bottle should have the time and nurses initials marked on it but it doesn't. V8 stated there is no way to know when that bottle was hung or that it belongs to R84. V8 LPN stated (R84's) Jevity feeding was started late. It is 8:45 AM and it is still running. If it were started on time, it should have been done by 3:00 AM. Now I have to let it run all day even when (R84) is eating. That could cause her stomach upset. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.) R321's undated Face Sheet documents R321's medical diagnoses as Encephalopathy, Ischemic Cardiomyopathy, Heart Disease, Muscle Wasting and Atrophy, Acute Kidney Failure, Esophageal Obstruction, Diabetes Mellitus Type II, Other Specified Disease of the Pancreas, Pneumonia, Pleural Effusion, Peritoneal Abscess, Pneumonitis due to Inhalation of Food and Vomit, Chronic Diastolic Congestive Heart Failure, Cardiac Vascular Implant and Graft, Gastroesophageal Reflux Disease (GERD), Implanted Cardiac Defibrillator, Colostomy Status, Hemiplegia and Hemiparesis following Cerebral Infarction affecting Right Dominant side and Transischemic Attack (TIA). R321's Minimum Data Set (MDS) dated [DATE] documents R321 as cognitively intact. This same MDS documents R321 requires moderate assistance with toileting, maximum assistance with dressing, personal hygiene, bed mobility and is dependent on staff for transfers. R321's Physician Order Sheet (POS) dated October 2024 documents a physician order starting 9/23/24 and discontinued 10/2/24 for R321's enteral feed to begin in the evening for poor appetite/malnutrition Jevity 1.2 calories/milliliter (ml) for 12 hours 7:00 PM-7:00 AM, flush with 100 ml water before and after feeding, eats a regular diet from 7:00 AM-7:00 PM. R321's Care plan intervention dated 9/26/24 instructs staff to keep R321's head of bed elevated. On 10/1/24 at 1:30 PM, R321 was laying in his bed in his room with his head of bed flat. R321's enterel feeding bottle was hanging from a pole directly next to R321's bed. R321's enterel feeding was connected and running into R321's Gastrostomy tube (G-Tube). R321's enteral feeding bottle was not labeled with R321's name, time administered, name of product, instructions on what rate to run his enteral feeding or how long to run R321's enteral feeding. On 10/2/24 at 8:27 AM, R321 was laying in his bed in his room. R321's enteral feeding bottle was hanging from a pole directly next to R321's bed. R321's enteral feeding was connected and running into R321's Gastrostomy tube (G-Tube). R321's enteral feeding bottle was not labeled with R321's name, time administered, name of product, instructions on how fast to run enteral feeding or how long to run R321's enteral feeding. On 10/2/24 at 8:28 AM, R321 stated I don't feel good. I feel blah. My stomach hurts. as V8 Licensed Practical Nurse (LPN) was assessing R321. On 10/2/24 at 8:31 AM, V8 Licensed Practical Nurse (LPN) stated R321's label on his enteral feeding bottle should be filled out. V8 stated V8 would not have any idea from reading that bottle of enteral feeding when it was started or how much to administer. V8 LPN stated I looked up (R321's) enteral feeding order and is was supposed to start at 7:00 PM last night. It was signed off as being administered at 11:02 PM. If I were to follow the order, I should have disconnected it at 7:00 AM and (R321) would have lost out on four hours of enteral feeding. That is why it is important to label those enteral feeding bottles. On 10/3/24 at 10:15 AM, V2 Director of Nurses (DON) stated enteral feeding bottles should be labeled with the date, time of administration, the nurses initials who administered the feeding and how fast it is supposed to run. V2 DON stated that gives the bedside nurse the information she needs. V2 DON stated any resident that is receiving enteral nutrition should have their head of bed raised during that administration of feeding and for 60 minutes afterwards. V2 DON stated I don't believe we (facility) have a policy on this but it is the expectation.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35380 Based on interview and record review, the facility failed to provide follow-up care for residents who continued to have behaviors despite non-pharmacological interventions being used for four residents (R9, R16, R101, R104) and failed to refer a resident (R18) to behavioral health services after R18 made a suicidal statement. These failures affected five residents (R9, R16, R18, R101, R104) out of six residents reviewed for behavioral health services in a sample list of 75 residents. Findings include: The facility's Condition Change Documentation Policy dated 9/28/09, documents to maintain a medical record that is reflective of documentation of the care provided to resident's to include notifications related to the change of a resident's condition; documents any nursing interventions or treatments provided to the resident as indicated by the nature of the condition and current physician orders; notify the physician of change of condition and document any physician orders received. 1). R9's undated Medical Diagnoses list documents R9's diagnoses as: Alzheimer's Disease, Dementia in other diseases classified elsewhere, moderate, with other behavioral disturbance; Anxiety Disorder, unspecified, and other recurrent Depressive Disorders. R9's Care Plan dated 10/2/24, documents R9's behaviors as: episodes of impaired moods/behaviors, physical behaviors such as throwing items at others, poking others, yelling at others, slamming walker down, hitting self, and rejection of care. 2.) R16's undated Medical Diagnoses list documents R16's diagnosis as: Unspecified Dementia, severe with psychotic disturbance. R16' Care Plan dated 7/17/24, documents R16's behaviors as episodes of impaired mood/behaviors, history of hallucinations, delusions, and false beliefs. 3.) R101's undated Medical Diagnoses list documents R101's diagnoses as: unspecified Dementia, severe with agitation, unspecified Dementia with severity with mood disturbances, major Depressive Disorder, recurrent, moderate, and Anxiety Disorder. R101's Care Plan dated 7/8/24, documents R101 has alteration in thought processes, history of anxiety and depression, history of delusions, and false beliefs. 4.) R104's undated Medical Diagnoses list documents R104's diagnoses as: Alzheimer's Disease with late onset, dementia in other diseases classified elsewhere, severe with agitation, and Anxiety disorder. R104's Care Plan dated 7/24/24, documents R104 has Impaired mood/behaviors, Delusions, rejection of care, physical behaviors such as hitting others, swinging purse, throwing things, exit seeking, yelling, and screaming. There was no documentation related to the effectiveness of non-pharmacological interventions for R9, R16, R101, R104. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/5/24 at 1:19 PM, V2 Director of Nursing (DON) stated the expectation is if behaviors remain after non-pharmacological interventions are tried, the nurse should contact the doctor and family to determine what the next step will be for managing behaviors. V2 stated whatever follow-up is done, should be documented in the progress notes. V2 stated there is no further follow-up documented for some behaviors that remained after non-pharmacological interventions were tried or worsened and failed for R9, R16, R101, and R104. V2 also stated they do not have another policy for behaviors except for the Severe Behavior Policy. 41970 5.) R18's undated Face Sheet documents R18's medical diagnoses as Metabolic Encephalopathy, Diabetes Mellitus Type II, Muscle Wasting and Atrophy, Parkinson's Disease and Chronic Kidney Disease Stage 3. R18's Minimum Data Set (MDS) dated [DATE] documents R18 as moderately cognitively impaired. This same MDS documents R18 requires moderate assistance with toileting, bathing, dressing, personal hygiene, bed mobility and transfers. R18's Care plan initiated 6/14/24 does not document any new behavioral interventions after R18 made a self harm statement on 8/12/24. R18's Nurse Progress Note dated 8/12/24 at 5:30 PM documents (R18) stated, I want to kill myself. (R18) asked if she has a plan. (R18) stated, yes I do but I am not going to tell you. Orders received per Physician (MD) to keep (R18) in house. (R18) did not need to be sent to emergency room due to stable vital signs and no threat to herself or others. (R18) placed on 15 minute rounders and all items removed from room that can cause harm. R18's Nurse Progress Note dated 8/14/24 at 10:02 AM documents (R18) remains on suicide watch. 15 minute rounders in place. R18's Behavior Tracking dated 9/2/24-10/2/24 documents four entries. No further behavior tracking was documented. On 10/3/24 at 1:35 PM, V2 Director of Nurses (DON) stated R18 did make a statement indicating R18 wanted to kill herself. V2 DON stated the facility notified the Physician and R18's representative. V2 DON stated there was no discussion about referring R18 to behavioral health services. V2 DON stated R18 was having a difficult time adjusting to living in our facility. V2 stated R18 was originally going to go back to her home, but it was decided that R18 would not be safe at her home and needs 24 hour care and supervision. V2 DON stated We (facility) should have at least discussed referring (R18) to behavioral services. (R18) did seem to come out of her down time but it would have been worthy discussion. The facility policy Behavior (Serious Behavior) Emergency reviewed September 2011 documents, The facility will ensure that a resident who displays a serious behavior emergency, i.e. any suicide attempts or threats, any physical acts which cause injury or potential injury to the resident, employees, visitors or other residents, and any behavior exhibited which requires constant staff intervention will receive appropriate referral, treatment and services.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on observation, interview and record review the facility failed to administer medications per the physician order for one (R321) resident out of five residents reviewed for medication administration in a sample list of 75 residents. This failure resulted in two medication errors out of 26 opportunities, 7.69% medication error rate. Findings include: The facility policy titled Medication Administration dated 1/11/2010 documents the facility will accurately administer medication following Physician's orders. R321's undated Face Sheet documents R321's medical diagnoses as Encephalopathy, Ischemic Cardiomyopathy, Heart Disease, Muscle Wasting and Atrophy, Acute Kidney Failure, Esophageal Obstruction, Diabetes Mellitus Type II, Other Specified Disease of the Pancreas, Pneumonia, Pleural Effusion, Peritoneal Abscess, Pneumonitis due to Inhalation of Food and Vomit, Chronic Diastolic Congestive Heart Failure, Cardiac Vascular Implant and Graft, Gastroesophageal Reflux Disease (GERD), Implanted Cardiac Defibrillator, Colostomy Status, Hemiplegia and Hemiparesis following Cerebral Infarction affecting Right Dominant side and Transischemic Attack (TIA). R321's Minimum Data Set (MDS) dated [DATE] documents R321 as cognitively intact. This same MDS documents R321 requires moderate assistance with toileting, maximum assistance with dressing, personal hygiene, bed mobility and is dependent on staff for transfers. R321's Physician Order Sheet (POS) dated October 2024 documents a physician order starting 9/24/24 and discontinued 10/3/24 to administer Dapagliflozin Propanediol (Farxiga) Oral Tablet 5 milligrams (mg) daily for Diabetes Mellitus. This same POS documents a physician order for Lansoprazole Suspension 3 milligrams (mg)/milliliter (ml) starting 9/24/24 with no end date listed. Give 10 ml via Gastrostomy Tube (G-Tube) in the morning for 30 days. R321's Nurse Progress Note dated 10/2/24 at 8:00 AM, documents Late Entry: 10/4/24 at 7:34 AM (R321's) Lansoprazole and Farxiga not administered by nurse. Lansoprazole had not been sent yet because of waiting on pharmacy to complete insurance authorization. Farxiga was in process of being re-ordered and was sent on the night of 10/2/2024. On 10/2/24 at 8:15 AM, V8 Licensed Practical Nurse (LPN) searched through the medication cart and medication supply room for R321's Lansoprazole and Farxiga. V8 LPN could not find either medication. On 10/2/24 at 8:20 AM, V8 Licensed Practical Nurse (LPN) stated R321 does not have any Lansoprazole or Farxiga. V8 LPN stated (R321) is the only resident who gets Lansoprazole in suspension form. The other nurses couldn't borrow it from someone because no one else has that order. (R321's) Farxiga and Lansoprazole has been signed out. I will have to investigate with pharmacy. (continued on next page)

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	145772	A. Building B. Wing	10/08/2024

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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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/3/24 at 2:00 PM, V2 Director of Nurses (DON) stated all residents should have their medications available to them at all times. V2 DON stated there might be times the pharmacy is running late but the medication should generally be in the medication cart or medication storage room. V2 DON stated R321 did not have his Lansoprazole or Farxiga available.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on observation, interview and record review the facility failed to administer physician prescribed medications to one (R321) resident out of five residents reviewed for significant medication errors in a sample list of 75 residents. R321 experienced Gastrointestinal (GI) upset, malaise and was hospitalized as a result of R321 missing multiple doses of medications for blood glucose control and Gastroesophageal Reflux Disease (GERD). Findings include: R321's undated Face Sheet documents R321's medical diagnoses as Encephalopathy, Ischemic Cardiomyopathy, Heart Disease, Muscle Wasting and Atrophy, Acute Kidney Failure, Esophageal Obstruction, Diabetes Mellitus Type II, Other Specified Disease of the Pancreas, Pneumonia, Pleural Effusion, Peritoneal Abscess, Pneumonitis due to Inhalation of Food and Vomit, Chronic Diastolic Congestive Heart Failure, Cardiac Vascular Implant and Graft, Gastroesophageal Reflux Disease (GERD), Implanted Cardiac Defibrillator, Colostomy Status, Hemiplegia and Hemiparesis following Cerebral Infarction affecting Right Dominant side and Transischemic Attack (TIA). R321's Physician Order Sheet (POS) dated October 2024 documents a physician order starting 9/24/24 and discontinued 10/3/24 to administer Dapagliflozin Propanediol (Farxiga) Oral Tablet 5 milligrams (mg) daily for Diabetes Mellitus. This same POS documents a physician order for Lansoprazole Suspension 3 milligrams (mg)/milliliter (ml) starting 9/24/24 with no end date listed. Give 10 ml via Gastrostomy Tube (G-Tube) in the morning for 30 days. R321's Minimum Data Set (MDS) dated [DATE] documents R321 as cognitively intact. This same MDS documents R321 requires moderate assistance with toileting, maximum assistance with dressing, personal hygiene, bed mobility and is dependent on staff for transfers. R321's Care Plan intervention dated 6/18/24 instructs staff to administer Gastrointestinal (GI) medications/laxatives/stool softeners as ordered. Assess for symptoms such as pain, bloating reflux, abnormal bowel function, nausea/vomiting, discomfort/pain upon defecation, blood in stool, black stools, hard/dry stools, mucous, signs of hemorrhoids. This same care plan instructs staff to administer diabetic medication/insulin as ordered. R321's Medication Administration Record (MAR) dated September 2024 documents R321 was administered Farxiga 5 milligrams (mg) on 9/24-9/27, 9/29 and 9/30. This same MAR documents R321's Farxiga was not administered on 9/28/24. This same MAR documents R321's Lansoprazole 3 milligrams (mg)/milliliter (ml) was not administered on 9/24, 9/27, 9/28 and 9/29. This same MAR documents R321's Lansoprazole was administered on 9/25, 9/26 and 9/30. R321's Medication Administration Record (MAR) dated October 2024 documents R321 was administered Farxiga 5 milligrams (mg) on 10/1/24 and not on 10/2/24. This same MAR documents R321 was not administered Lansoprazole 3 milligrams (mg)/milliliter (ml) give 10 ml 10/1/24-10/3/24. R321' Nurse Progress Note dated: (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	-10/2/24 at 8:00 AM documents Late Entry: 10/4/24 at 7:34 AM (R321's) Lansoprazole and Farxiga not administered by nurse. Lansoprazole had not been sent yet because of waiting on pharmacy to complete insurance authorization. Farxiga was in process of being re-ordered and was sent on the night of 10/2/2024. (R321) unsure exactly what meds he didn't take. (V22) Physician notified and no new orders given for Farxiga. Instructed to consult Gastrointestinal Physician regarding Lansoprazole which was changed to Omeprazole by mouth. -10/2/24 at 1:18 PM documents Faxed (V22) Physician and made aware that Farxiga 5 mg was not given this am, and also noted that his insurance will not cover his Lansoprazole oral suspension 3 mg/ml, that his cost out of pocket is plus $600. Spoke with pharmacy, included this information with fax to (V22) Physician, awaiting any new order, Farxiga will be sent out this evening. -10/2/24 at 5:16 PM documents Received fax from pharmacy at this time, (R321) insurance prefers the brand name Dapagliflozin (Farxiga) they will be sending the Brand name Farxiga moving forward. -10/3/24 at 1:45 PM documents New order for Omeprazole 20 mg by mouth daily. -10/3/24 at 11:54 PM documents (R321) complained of malaise and stomach ache. First attempt via automatic blood pressure (BP) wrist cuff 87/39, second attempt manual BP 87/38. (R321) stated, I just feel blah. (V22) Physician paged via telephone. Nurse waiting for return call. -10/4/24 at 1:04 AM documents (R321) continued to complain of stomach pain and malaise. Ambulance notified via telephone for transfer to emergency room for evaluation and treatment. On 10/2/24 at 8:15 AM V8 Licensed Practical Nurse (LPN) searched through the medication cart and medication storage room looking for R321's Lansoprazole and Farxiga. V8 LPN did not find those two medications. On 10/2/24 at 8:28 AM, R321 was laying in his bed with head of bed flat. R321's enteral feeding was running. R321's skin was pale. R321's voice was soft and raspy. R321's hand was rubbing his abdomen area. R321 stated I don't feel good. I feel blah. My stomach hurts. as V8 Licensed Practical Nurse (LPN) was assessing R321. On 10/2/24 at 8:20 AM V8 Licensed Practical Nurse (LPN) stated R321 does not have any Lansoprazole or Farxiga. V8 LPN stated (R321) is the only resident who gets Lansoprazole in suspension form. The other nurses couldn't borrow it from someone because no one else has that order. (R321's) Farxiga and Lansoprazole has been signed out. I will have to investigate with pharmacy. On 10/2/24 at 4:00 PM, V8 Licensed Practical Nurse (LPN) stated I spoke with pharmacy. (R321's) Lansoprazole was waiting on insurance and so the pharmacy never did even send it. (R321's) Farxiga was never re-ordered when he came back from the hospital on 9/23/24. I don't know why other nurses have been signing those two medications out because they weren't here to give. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	On 10/3/24 at 2:00 PM, V2 Director of Nurses (DON) stated R321 had missed doses of his Lansoprazole and Farxiga. V2 DON stated V2 called the pharmacy and verified the number of doses sent to the facility and when. V2 DON stated through V2's investigation, R321 did miss multiple doses of his Farxiga and Lansoprazole. V2 DON state nurses should only sign off that a medications been given if the resident actually got the medication. V2 DON stated if a resident misses a dose of any medications, there should be documentation as to why and that the proper people should be notified with multiple missed doses. V2 DON stated V2 was not certain why R321's Farxiga and Lansoprazole were signed out as given when they were not. V2 DON stated V2 would investigate this further and educate staff on medication administration and documentation. V2 DON stated the facility does not have a medication error rate policy but would assume that it is a standard of care to investigate and document why a resident would miss multiple doses of medications including notifications and any effect on the resident. V2 DON stated the facility does not have a policy for medication errors. V2 stated the expectation is for the nurses to self-report to V2 who would then do an investigation. V2 DON stated I was not aware (R321) not receiving his medications until yesterday (10/2/24). On 10/4/24 at 2:55 PM, V33 Pharmacy Technician Data Entry Specialist stated R321's Farxiga was delivered to the facility on [DATE]. V33 stated that would be a 14 day supply (14 doses). V33 stated R321's Farxiga should have lasted until 8/30/24. V33 stated R321 would have missed nine consecutive doses from 9/24/24-10/2/24. V33 stated Farxiga was not sent any other times. V33 stated R321's Lansoprazole required authorization from his insurance company which was never obtained. V33 stated R321's Lansoprazole was never sent to the facility. V33 stated R321 would have missed eight consecutive doses from 9/25/24-10/2/24. On 10/4/24 at 3:10 PM, V34 Pharmacist stated Lansoprazole and Pantoprazole have similar effects on the body. V34 stated If someone like (R321) with severe Gastrointestinal (GI) disease did not get these medications it could certainly contribute to GI distress and put him at a higher risk of having GI complications. (R321's) hospitalization in part could be caused by him not receiving his prescribed medications. V34 Pharmacist stated R321 should have his blood glucose monitored regularly due to R321 is receiving enteral feedings as his main nutritional source. On 10/8/24 at 3:00 PM, V22 Physician/Medical Director stated R321 has a long standing history of Gastrointestinal Disease. V22 stated R321 was recently hospitalized for GI issues. V22 stated R321 needs his Lansoprazole for his Gastroesophageal Reflux Disorder (GERD) or he will become symptomatic. V22 stated symptoms may include GI upset, malaise, nausea, vomiting or a feeling of fullness. V22 stated it is important for R321 to receive his prescription medications including the Lansoprazole to avoid being re-hospitalized . V22 stated R321 has a medical diagnosis of Diabetes Mellitus Type II and also requires his medication (Farxiga) to help to lower his blood glucose levels. V22 stated R321 missing so many doses of his Lansoprazole and Farxiga with no notification to V22 is unacceptable. V22 stated R321 was re-hospitalized on [DATE] due to GERD symptoms. V22 stated the facility failing to administer R321's prescribed medications attributed to the fact that R321 has been hospitalized twice in the recent past for the same symptoms related to his Diabetes and GERD.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 31642 Based on observation, interview and record review the facility failed to ensure only licensed personnel had access to the west hall medication room keys. This failure had the potential to affect all 46 of 46 residents (R1, R2, R3, R6, R7, R8, R10, R11, R13, R17, R18, R23, R25, R26, R29, R30, R33, R42, R45, R48, R50, R53, R54, R57, R60, R62, R63, R65, R70, R72, R74, R76, R77, R79, R81, R84, R85, R86, R93, R100, R103, R105, R113, R143, R152, and R321) reviewed for west hall, medication storage on the sample list of 75. Findings include: On 10/3/24 at 1:00 pm, V28, Certified Nursing Assistant (CNA) approached V25, Licensed Practical Nurse (LPN) on the west hall of the facility. V28, CNA asked for the west hall medication room keys. V28 stated he needed to get ice packs for a resident (unidentified). V25, LPN handed V28, CNA the medication room door keys, without hesitation. V28, CNA walked down the hall approximately 50 feet to the nurses station, turned right, out of V25, LPN sight, and walked over ten feet to the medication room door. This surveyor followed V28, CNA while V25, LPN remained at the wound treatment cart. V28, CNA unlocked the west medication room door. V25, LPN hurriedly rushed down the hall and approached the medication room door as it was closing. V25, LPN grabbed the medication room door, opened the door, and V25 stood in the doorway, as V28 retrieved an ice pack from the medication room freezer. V25, LPN stated I don't know why I did that. I really never let the keys (medication room) out of my sight. On 10/3/24 at 2:30 pm V2, Director of Nursing stated The medication room keys should have never been handed to a CNA (V28). We do have an emergency exit door, used for ambulance service, on the same med (medication) room key ring. A CNA may have a nurse hand them the keys in the event of an emergency. The nurse still has to watch the CNA the entire time. That is the only scenario. Never should any nurse hand the keys to anyone to go in the med room. The nurse must have them (medication room keys) in her possession at all times. The facility policy Storage of Medications dated 5/23/24 documents the following: POLICY: Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. The facility CMS-802 form dated 10/01/24 documents 46 residents reside on the west hall of the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on observation, interview and record review the facility failed to wear the appropriate Personal Protective Equipment (PPE) during medication administration for a resident (R224) on Contact Isolation Precautions, failed to properly dispose of contaminated PPE for a resident (R321) on Enhanced Barrier Precautions (EBP), failed to complete hand hygiene during wound care and catheter care for a resident (R26) on EBP and failed to wear the appropriate PPE during incontinence care and catheter care for a resident (R17) on EBP. These failures affect four (R17, R26, R224, R321) out of four residents reviewed for infection control in a sample list of 75 residents. Findings include: The facility policy titled Contract Precautions Protocol revised July 26, 2021 documents a gown should be worn when it is anticipated that clothing will have substantial contact with the resident, environmental survfaces, or items in the resident's room, or if the resident is incontinennt or wound drainage is not contained by a dressing. The facility policy titled Enhanced Barrier Precautions Protocol revised July 26, 2021 documents the facility will position a trash can near the exit for disposing of PPE after removal, prior to exit of residents' room or prior to providing care for another resident in the same room. 1.) R224's undated Face Sheet documents medical diagnosis as Vancomycin Resistant Enterococci (VRE) of Urine. R224's Minimum Data Set (MDS) dated [DATE] documents R224 as cognitively intact. R224's Physician Order Sheet (POS) dated October 2024 documents a physician order for Ertapenem 1 Gram Intravenously through the midline daily. On 10/2/24 at 11:50 AM, R224's room door had a sign posted which stated Contact Precautions. R224 had an isolation bin set up outside of her room which contained Personal Protective Equipment (PPE). On 10/2/24 at 11:51 AM, V9 Registered Nurse (RN) did not wear a PPE gown to administer R224's Midline Intravenous (IV) antibiotic. V9's scrub top and pants came in contact with R224's bed linens that R224 had been adjusting. On 10/2/24 at 11:55 AM, R224 stated I have a really bad infection in my urine. Sometimes I use the bedpan but the girls (staff) have to change me (provide incontinence care) sometimes too. I am supposed to be on isolation because my infection is so bad. On 10/2/24 at 12:00 PM, V9 Registered Nurse (RN) stated V9 should have worn a gown when administering R224's IV antibiotic. V9 stated I know (R224) was on contact precautions and should have worn the proper Personal Protective Equipment (PPE). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.) R321's undated Face Sheet documents R321's medical diagnoses as Encephalopathy, Ischemic Cardiomyopathy, Heart Disease, Muscle Wasting and Atrophy, Acute Kidney Failure, Esophageal Obstruction, Diabetes Mellitus Type II, Other Specified Disease of the Pancreas, Pneumonia, Pleural Effusion, Peritoneal Abscess, Pneumonitis due to Inhalation of Food and Vomit, Chronic Diastolic Congestive Heart Failure, Cardiac Vascular Implant and Graft, Gastroesophageal Reflux Disease (GERD), Implanted Cardiac Defibrillator, Colostomy Status, Hemiplegia and Hemiparesis following Cerebral Infarction affecting Right Dominant side and Transischemic Attack (TIA). R321's Minimum Data Set (MDS) dated [DATE] documents R321 as cognitively intact. This same MDS documents R321 requires moderate assistance with toileting, maximum assistance with dressing, personal hygiene, bed mobility and is dependent on staff for transfers. R321's Care plan intervention dated 6/18/24 documents R321 is on Enhanced Barrier Precautions (EBP) due to having a Gastrostomy tube (G-Tube), Colostomy and Urinary Catheter. On 10/2/24 at 8:25 AM, V8 Licensed Practical Nurse (LPN) administered R321's medications. R321 is on Enhanced Barrier Precautions (EBP) due to have a Gastrostomy tube (G-Tube). V8 LPN obtained R321's blood pressure, pulse, respirations and oxygen saturation. V8's disposable gown and gloves touched R321's blankets, flat sheet that was touching R321's G-Tube, R321's enterel feeding tube pole and bottle of Jevity. V8 LPN also assisted R321 in drinking a glass of water. V8 LPN then exited R321's room and placed her contaminated gown and gloves on the top of her medication cart sitting in the hallway outside R321's room. V8 LPN left the medication cart and returned a few minutes later. V8 LPN then placed the contaminated gown and gloves in the small side garbage can attached to the medication cart. V8 LPN did not disinfect the medication cart prior to administering medications to several other residents. On 10/2/24 at 8:30 AM, V8 Licensed Practical Nurse (LPN) stated V8 should have disposed of her contaminated PPE in the designated bins in R321's room. V8 LPN stated I don't know what I was thinking. I was just in a hurry I guess. I contaminated the entire medication cart by doing that. On 10/2/24 at 1:00 PM, V31 Infection Preventionist stated staff should wear Personal Protective Equipment (PPE) of a gown and gloves when caring for any resident on contact isolation precautions. V31 IP stated It doesn't matter if the contact is direct or indirect, the staff should be wearing gloves and gown. V31 IP stated R224 had active Vancomycin Resistant Enterococci (VRE) in her urine and is incontinent of urine. V31 IP stated not wearing a gown while providing cares for R224 could result in worsening or spread of R224's infection. V31 IP stated all contaminated PPE should be disposed of in the designated PPE disposal bins. V31 IP stated by V8 Licensed Practical Nurse (LPN) putting her contaminated gloves and gown on the top of the medication cart, then continuing on with medication administration to other residents, V8 exposed multiple residents to a higher risk of being exposed to infectious organisms. 31642 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.) On 10/2/24 at 12:35 pm, R17 had an enhance barrier precaution sign on R17's door. R17's door also had a door hanger with separate compartments. The door hanger compartments contained Personal Protective Equipment (PPE), which included surgical mask, gloves and gowns. Without donning PPE, mask, gloves or gowns, CNA's V16, Certified Nursing Assistant (CNA) student, and V17, CNA student, entered R17's room, with V14, CNA and V15, CNA and washed their hand and donned gloves. V14 and V15 transferred R17 to bed via a full body mechanical left, while V16 and V17 observed. V14 and V15 provided R17 incontinence care and urinary indwelling catheter care. On 10/2/24 at 12:50 pm V14 and V15 CNA and both V16 and V17 student CNA's exited R17's room. V14, V15, V16 and V17 confirmed they did not don any PPE other then gloves. V15, CNA stated V15 and V14, CNA provided the mechanical lift transfer, incontinence's care and catheter care and empty the bedside drainage bag while the two student CNA observed. V15 stated R17 is on enhanced barrier precautions and all staff performing care, should have worn PPE. V14 then stated I know too. We were just really busy down here. On 10/2/24 at 1:00 pm V12, Nurse Practitioner/ CNA Student Coordinator stated Though the students (V16 and V17) were only observing the care, I understand why they should have gowns and gloves on during observations. 4.) R26's Physician Order Sheet documents the following treatment orders: 1. Cleanse open fistula area on L (left) hip with wound wash or NS (normal saline), apply collagen to wound bed then apply Calcium Alginate et (sic), cover with Border (bordered) foam. (Do Not apply border gauze), daily. 2. Cleanse area to RLE (right lower extremity) with wound wash or NS. Apply collagen to wound bed et.(sic) cover with border foam. (DO NOT use border gauze), daily. 3. Apply desitin to area on right buttock, two times a day. 4. Apply skin prep to R (right) heel, two times a day. 5. May use house barrier cream after each episode of incontinence and PRN (as needed). May keep at bedside. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/3/24 at 1:05 pm, R26 had an enhanced barrier precaution sign on her door, and PPE set up hanging on the door. V25, Licensed Practical Nurse (LPN) used hand sanitizer, donned gloves and a gown and entered R26's room. R26 laid on her back in bed. V25 removed R26's socks assessed R26's heels, cleansed the unopened dark pink area of R26's right heel with wound cleanser and applied skin prep. V25 laid the wound cleanser bottle directly on R26's bed sheet. V25 LPN removed her gloves and donned clean gloves without washing her hands or using hand sanitizer. V25, LPN removed R26's right shin bordered foam dressing. There was a small amount of serous drainage present on the soiled dressing. V25, LPN laid the soiled dressing directly on the R26's fitted sheet, next to R26's legs and the wound cleanser bottle. V25 removed her soiled gloves and placed the soiled gloves on the fitted sheet next to the soiled four by four bordered foam dressing. V25 applied a new pair of gloves, reaching into the box of gloves with her unwashed hands, unsantitized hand. V25 then used wound cleanser and gauze to clean R26 right lower leg wound. V25 laid the wound cleanser bottle back down on the sheet, abutting the same soiled dressing, and soiled gloves. V25 removed her soiled gloves, did not perform hand hygiene, donned new gloves and cut collagen pad to fit into the wound bed of R26's shin wound. With the same soiled gloves, V25 cleansed R26's right shin and applied a bordered foam dressing, labeled and dated the dressing with the same gloves on. R25 gathered the soiled items off the bed sheet and disposed of the soiled dressing gauze and soiled gloves in a plastic trash bag. V25 placed the now soiled wound cleanser bottle on a clean field that was set up on R26's bedside table for R26's left anterior hip pressure ulcer. V25, LPN then removed her soiled gloves and did not perform hand washing or use hand sanitizer. V25 applied a new pair of gloves, after reaching into the box of gloves with her unwashed hands. V25 pulled the left side of R26's pants down. V25 stated there is fissure on her left anterior hip. R26 did not have a dressing on open fissure. V25 removed her gloves and donned new gloves without using hand sanitizer or washing her hands, V25 cleaned the nickel sized fissure with wound cleaner, did not perform hand hygiene or change her gloves after cleansing. V25 cut and applied calcium alginate and collagen to wound bed area size, and covered with a bordered foam dressing. V25 removed gloves and did not wash hands or perform hand hygiene. V25 then stated she needed to get a CNA to help reposition R26. V25 went to the door, touching the handle and the door and got V3, Certified Nursing Assistant (CNA) for help positioning R26. V3, CNA washed her hands and donned gloves and gown. V25 removed her soiled gloves and applied new gloves without washing her hands or using hand sanitizer. V3, Certified Nursing Assistant and V25, LPN positioned R26 in a left side lying position. R26 was incontinent a small amount of feces. V25 cleaned R26's small incontinence of feces, and removed her gloves. V25 did not perform hand hygiene and donned clean gloves. V25 cleaned R26's coccyx with wound cleanser and four by four gauze. R26 had nine pencil sized, unopened red sores with peeling dry skin, in a scattered fashion over an approximately five inches diameter deep red scarring skin on R26's coccyx. V25 LPN stated None of the areas are open now. The scar is from a previous pressure ulcer. (R26) had a coccyx pressure ulcer here we healed out. She (R26) has only had shearing areas on her coccyx, for quite awhile. We use the barrier cream to prevent further breakdown. V25 applied barrier cream to R26's coccyx and removed her gloves and donned new gloves without washing her hands or using hand sanitizer. V3 and V25 repositioned R26 to a back lying position. Washed their hands and left R26's room. On 10/03/24 at 1:40 pm, V25, LPN confirmed she had not washed her hands or used hand sanitizer between donning and doffing gloves to prevent cross contamination during wound and incontinence care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145772	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Odd Fellow-Rebekah Home	201 Lafayette Avenue East Mattoon, IL 61938

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy Wound and Ulcer Policy and Procedure dated 3/28/24 documents the following: It is the policy of this facility to provide nursing standards for assessment, prevention, treatment, and protocols to manage residents at any level of risk for skin breakdown and for wound management. The same policy directs staff to wash their hands or use hand sanitizer before and after donning gloves during wound care, to prevent cross contamination. The facility ENHANCED BARRIER PRECAUTIONS PROTOCOL dated 7/26/21 documents the following: Enhanced Barrier Precautions expands the use of Personal Protective Equipment (PPE) beyond situations in which exposure to blood and body fluids is anticipated, refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of Multi-Drug Resistant Organisms (MDROs) to staff hands and clothing. If Enhanced Barrier Precautions (EBP) are required, a sign should be placed outside the resident's room to assist in educating staff, residents, and visitors on appropriate personal protection. When required, Enhanced Barrier Precautions apply to everyone caring for the resident. PERSONAL PROTECTIVE EQUIPMENT *Hand hygiene practices must be followed. *PPE (e.g., gloves and gowns) should be used during high-contact resident care activities. Examples of high-contact resident care activities requiring gown and glove use include: *Dressing, *Bathing/showering, *Transferring, *Providing hygiene, *Changing linens *Changing briefs or assisting with toileting, *Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, *Wound care: any skin opening requiring a dressing *Do not wear the same gown and gloves for the care of more than one person., *Facilities should ensure PPE and alcohol-based hand rub are readily accessible to staff. ENHANCED BARRIER PRECAUTIONS MAY BE INDICATED FOR RESIDENTS WITH ANY OF THE FOLLOWING: *Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply, OR, *Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with MDRO. Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage (e.g., Band-Aid) or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. -Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. A peripheral intravenous line (not a peripherally inserted central catheter) is not considered an indwelling medical device for the purpose of EBP. -EBP should be used for any residents who meet the above criteria, wherever they reside in the facility.