| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145772 | A. Building<br>B. Wing | 11/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Odd Fellow-Rebekah Home | 201 Lafayette Avenue East<br>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 0557<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.<br><br>Based on observation, interview, and record review, the facility failed to keep residents' nurse call lights within reach of residents requiring staff assistance. This failure affects two residents (R5 and R57) out of nine reviewed for dignity and activities of daily living on the sample list of 45. Findings include: On 11/19/25 at 1:20 PM, R5 and R57, roommates, were both lying in their respective beds. Each of the resident's nurse call light activation devices were coiled in a circle and laying on the floor between the bed and wall behind the room divider curtain. On 11/19/25 at 1:20 PM, R5 only opened her eyes and stared when greeted verbally. R5 made no verbal response of her own. R57 stated if she needed some attention from the staff she would use the call light but didn't know where the call light was. R57 indicated the call light cord might be across the room by the dresser but she didn't have it. On 11/19/25 at 1:35 PM, V10, Restorative Registered Nurse, stated R5 probably would have the physical ability to use a call light but cognitively would not recognize what to do with the call light. V10 continued to state R57 would not be able to use a call light and was surprised when informed R57 had made statements indicating she would use the call light if she had it in reach. V10 concluded by stating she would make sure the two call lights got placed where the residents could use it if they needed staff assistance. R5's Brief Interview for Mental Status and Narrative Summary Score dated 8/6/25 documents R5 was rated as severely cognitively impaired. R57's Brief Interview for Mental Status and Narrative Summary Score dated 9/23/25 documents R57 was rated as severely cognitively impaired. |

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.

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

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to obtain a physician order for and assess a physical restraint placed on one (R62) resident out of two residents reviewed for restraints in a sample list of 45 residents. Findings include: R62's Minimum Data Set (MDS) dated [DATE] documents R62 as severely cognitively impaired. This same MDS documents R62 requires moderate assistance with toileting, bed mobility and transfers, maximum assistance with bathing and dressing and R62 is dependent on staff for assistance with personal hygiene. R62's Care plan intervention dated 12/5/24 documents R62 may use a self-release belt while up in wheelchair and release during rounds, Activities of Daily Living (ADLS), and during supervised activities. R62's Electronic Medical Record (EMR) does not document a physician order nor an assessment for the use of a physical restraint. R62's Physician Order Sheet (POS) dated November 2025 documents a physician order starting 12/5/24 to apply a self-release belt when up in wheelchair due to unsteadiness and weakness. To be removed with rounds, Activities of Daily Living (ADL) and supervised activities and as needed. This same POS does not document a physician order to apply a non-self releasing seat belt for R62. R62's restraint consent dated 6/9/25 documents verbal consent from R62's POS for a soft belt restraint. R62's Physical Device Evaluation dated 9/22/25 documents R62 may use a self-release belt when up in wheelchair. To be released with rounds, Activities of Daily Living (ADL), meals, and as needed (PRN). On 11/18/25 at 12:30 PM R62 was sitting by the nurses station in her wheelchair. R62 was sitting on a cushion with pommel. R62 had a cloth style lap belt with long straps around her mid section that were tied to the bottom of the back of the wheelchair. R62's lap belt is not self-releasing. On 11/19/25 at 2:45 PM R62 was sitting by the nurses station in her wheelchair. R46 was sitting on a cushion with pommel. R62 had a cloth style lap belt with long straps around her mid section that were tied to the bottom of the back of the wheelchair. On 11/20/25 at 8:40 AM V18 Registered Nurse (RN) asked R62 to remove her seatbelt. R62 was not able to remove her seatbelt independently. R62 stated 'I hate this thing' as she was pulling on the front of the lap belt. On 11/20/25 at 8:45 AM V18 Registered Nurse (RN) stated she is R62's 'regular' nurse. V18 RN stated R62 used to wear a seat belt that had a 'latch' in the front which R62 could remove by herself. V18 RN stated the facility changed to a soft seat belt that R62 cannot remove by herself. V18 RN stated R62 was falling 'every day or so' so she has to wear the seatbelt to keep her from falling. On 11/21/25 at 8:45 AM V2 Director of Nurses (DON) stated R62 has fallen multiple times and the facility has added a new intervention with each fall. V2 DON stated R62 used to wear the self releasing style of seat belt but was releasing the belt 'so many times' which resulted in falls the facility and R62's family decided to use the non-self releasing style of seat belt. V2 DON stated R62 is not able to release this new style of belt. V2 DON stated the change was made in June 2025. V2 DON confirmed the facility did not have a physician order or assessment for the physical restraint used on R62. V2 DON stated the facility errors have been 'fixed and now everything is in place' for a non-self releasing style of seat belt for R62. The facility policy titled Restraint Program Policy and Procedure revised November 10, 2015 documents prior to the use of any restraint, each resident is assessed for potential alternatives by using the restraint Pre-Restraining and Quarterly Evaluation assessment. Documentation of alternatives are then listed in the resident's plan of care. If a restraint is necessary, Physician and Power of Attorney (POA) are notified and a Restraint Consent is completed. A quarterly review of restraint use is done using the Pre-Restraint and Quarterly Evaluation to identify the least restrictive methods. Care Plans are adjusted as needed to reflect the resident's current status. Reduction attempts are documented. |

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| | 145772 | A. Building<br>B. Wing | 11/21/2025 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to prevent cross contamination during wound care for one (R46) out of three residents reviewed for wound care in a sample list of 45 residents. Findings include: R46's Electronic Medical Record (EMR) documents medical diagnoses as Atrial Fibrillation, Chronic Heart Failure, Non-Pressure Chronic Ulcer of the Right Foot and Peripheral Vascular Disease. R46's Minimum Data Set (MDS) dated [DATE] documents R46 as cognitively intact. This same MDS documents R46 requires moderate assistance with bed mobility and transfers and maximum assistance with toileting, bathing and dressing. R46's Physician Order Sheet (POS) dated November 2025 documents a physician order to Cleanse Right second toe with wound wash, do not scrub or use excessive force. Apply hydrogel to wound bed, then apply absorbent dressing and cover with absorbent pad, wrap with stretch gauze and secure with tape. On 11/18/25 at 12:20 PM V22 Licensed Practical Nurse (LPN) completed wound care for R46's Right Second toe arterial wound. R46's Right Second Toe had an open area that had moderate amount of yellow drainage. R46's Right Second toe had three yellow areas in the middle of her wound with a red and swollen periwound. V22 LPN set up R46's wound supplies on R46's table top. V22 LPN removed scissors from her scrub top pocket and cut R46's dressings to the size needed without disinfecting the scissors. V22 LPN then placed the cut dressing directly over R46's Right Second Toe Arterial wound. On 11/18/25 at 12:35 PM R46 stated she has poor circulation in her Right Lower Leg. R46 stated she has an infection in her Right Second toe open wound. On 11/18/25 at 3:40 PM V22 LPN confirmed she cross contaminated R46's Right Second toe arterial wound by using contaminated scissors to cut R46's supplies that she placed directly on R46's wound. V22 LPN stated cross contaminating a wound could cause an infection. On 11/20/25 at 11:00 AM V6 Infection Preventionist (IP) stated the nurses should disinfect their scissors prior to using them for any resident's wound care. V6 IP stated since the inside of nurses scrub top pockets are not 'clean,' the nurses should have cleaned off their scissors between removing them from their pockets and using them for wound care. V6 IP stated that is a potential way to spread bacteria. V6 IP stated she is 'constantly' in-servicing staff on infection control procedures and will continue training to remind staff to wear the appropriate PPE. The facility policy titled Dressing Change Aseptic Technique revised April 13, 2021 documents scissors used for dressing changes should be disinfected prior to and after use. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to prevent cross contamination during pressure ulcer care for one (R11) resident out of two residents reviewed for pressure ulcers in a sample list of 45 residents. Findings include: R11's Minimum Data Set (MDS) dated [DATE] documents R11 as severely cognitively impaired. This same MDS documents R11 is dependent on staff for oral hygiene, bathing, dressing, toileting, personal hygiene, bed mobility and transfers R11's Electronic Medical Record (EMR) documents medical diagnoses as Muscle Wasting and Atrophy, Wedge Compression Fracture of Second Lumbar Vertebra, Macular Degeneration, Sacral Pressure Ulcer and abnormalities of Gait and Mobility. R11's Physician Order Sheet (POS) dated November 2025 documents a physician order starting 8/25/25 to cleanse R11's area on Sacrum with wound wash, apply collagen powder to wound bed then pack wound with gauze soaked with quarter strength Bleach solution, cover with absorbent pad and secure with retention tape. R11's Wound Evaluation and Management Summary dated 11/14/25 documents R11's Stage 4 Sacral Pressure Ulcer as an open ulceration cluster wound measuring 1.0 centimeters (cm) long by 0.8 cm wide by 0.1 cm deep with moderate serous drainage. This same summary documents R11's Stage 4 Sacral Pressure Ulcer as 'Not at Goal'. R11's Pressure Ulcer Risk assessment dated [DATE] documents R11 as being a high risk for obtaining Pressure Ulcers. On 11/20/25 at 1:00 PM V29 Licensed Practical Nurse (LPN)/Wound Nurse and V30 Certified Nurse Aide (CNA) completed wound care for R11's Stage 4 Sacral Pressure Ulcer. As V29 LPN was preparing R11's wound dressings on the bedside table, the table was pushed into R11's privacy curtain. R11's privacy curtain directly touched the open top of R11's bottle of bleach solution and the entire length and a portion of the sides of R11's bedside table and the dressing supplies. V29 LPN did not disinfect her scissors after removing them from her scrub top pocket and before cutting R11's dressings. V29 LPN placed the contaminated dressing directly on R11's Stage 4 Sacral Pressure Ulcer. R11's Stage 4 Sacral Pressure Ulcer had a dark red center, white edges and dark red periwound and moderate serous drainage. V29 LPN measured R11's pressure ulcer during the treatment as being 1.0 centimeter (cm) long by 0.9 cm wide by 0.5 cm deep. On 11/20/25 at 1:25 PM V29 Licensed Practical Nurse (LPN)/Wound Nurse confirmed she cross contaminated R11's wound supplies by allowing R11's privacy curtain to touch the supplies and by not disinfecting her scissors prior to cutting R11's dressings. V29 LPN stated she cleaned the scissors prior to the dressing change but then 'forgot' and put them back into her pocket which was not clean. V29 stated cross contaminating an open wound could cause or worsen an infection. The facility policy titled Dressing Change Aseptic Technique revised April 13, 2021 documents scissors used for dressing changes should be disinfected prior to and after use. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>Based on observation, interview, and record review, the facility failed to provide appropriate urinary incontinence care for resident cleanliness. This failure affects ten residents (R2, R3, R5, R10, R52, R57, R77, R92, R94, R111) out of twenty-five residing on the facility [NAME] Hall on the sample list of 45. Findings include: On 11/18/25 from 9:30 AM until 4:15 PM, and 11/19/25 from 8:45 AM until 4:15 PM, there was a consistent, distinct, and moderately offensive urine odor in the facility's [NAME] Hallway. The urine odor was more pronounced in the resident rooms of R5, R57, R111, R52, R2, R77, R3, R92 and R94. Rooms of R111, R52, R2, R77, and R3 were noted to have hand-held plastic urinals. On 11/21/25 at 9:15 AM, the [NAME] Hall had noted urine odor in the hallway and pronounced around rooms of R92, R94, R3, R5 and R57. On 11/18/25 at 3:55 PM, during an unsolicited interview, R10 stated the facility staff do not wipe her clean when they change her incontinence undergarment, simply remove the wet one and place a new dry one. R10 further stated then she notices she smells like urine and puts her at risk for skin breakdown. R10's Brief Interview for Mental Status and Narrative Score document R10 received a 14 out of a possible 15, rating R10 as cognitively intact. R10's Care Plan dated as beginning 7/19/24 documents R10 is at risk for skin impairment, requires staff assistance for toileting hygiene, and barrier skin protection cream after incontinence episodes. On 11/19/25 at 11:45 AM, V7, Registered Nurse, stated she had to monitor the agency staff working in the facility because she had found the agency staff would change residents' incontinence undergarments but leave the absorbent pad on the bed soaking wet. V7 continued stating the urine odor would permeate from the resident rooms into the hallways. V7 stated she had addressed the issue with the agency staff because that practice is not acceptable. The facility's Form 802 Resident Matrix dated 11/18/25 documents R2, R3, R5, R10, R52, R57, R77, R92, R94, R111 reside on the [NAME] Hall |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to wear appropriate Personal Protective Equipment (PPE) when providing wound care for one (R46) resident on Enhanced Barrier Precautions (EBP) out of one resident reviewed for isolation precautions in a sample list of 45 residents. Findings include:R46's Electronic Medical Record (EMR) documents medical diagnoses as Atrial Fibrillation, Chronic Heart Failure, Non-Pressure Chronic Ulcer of the Right Foot and Peripheral Vascular Disease. R46's Minimum Data Set (MDS) dated [DATE] documents R46 as cognitively intact. This same MDS documents R46 requires moderate assistance with bed mobility, transfers and maximum assistance with toileting, bathing and dressing. R46's Physician Order Sheet (POS) dated November 2025 documents a physician order to Cleanse Right second toe with wound wash, do not scrub or use excessive force. Apply hydrogel to wound bed, then apply absorbent dressing and cover with absorbent pad, wrap with stretch gauze and secure with tape. R46's Care Plan intervention dated 4/16/25 documents R46 requires Enhanced Barrier Precautions (EBP) per Centers for Disease Control (CDC) guidelines due to wounds. On 11/18/25 at 12:15 PM R46's door to her room displayed a sign that read Enhanced Barrier Precautions (EBP). R46's room had a cart outside the room that housed Personal Protective Equipment (PPE). On 11/18/25 at 12:20 PM V22 Licensed Practical Nurse (LPN) completed wound care for R46's Right Second toe arterial wound. R46's Right Second Toe had an open area that had moderate amount of yellow drainage. R46's Right Second toe had three yellow areas in the middle of her wound with a red and swollen periwound. V22 LPN did not wear an isolation gown when providing wound care for R46's open Right Toe wound. On 11/18/25 at 12:35 PM R46 stated she has poor circulation in her Right Lower Leg. R46 stated the nurses do not 'usually' wear a gown when providing wound care. R46 stated I have my Master's degree in Bacteriology. I know how bacteria spread and grow. R46 stated the staff should 'absolutely' wear both gown and gloves when caring for her Right Second toe Arterial wound. On 11/18/25 at 3:50 PM V22 Licensed Practical Nurse (LPN) stated she did know that R46 was on Enhanced Barrier Precautions (EBP). V22 LPN stated R46 is on antibiotics for her toe wounds and requires isolation precautions. V22 LPN stated she should have worn an isolation gown to help prevent the spread of any bacteria. On 11/20/25 at 11:00 AM V6 Infection Preventionist (IP) stated staff should wear Personal Protective Equipment (PPE) of a gown and gloves when providing wound care for R46's open toe wounds. V6 IP stated she is 'constantly' in-servicing staff on infection control procedures and will continue training to remind staff to wear the appropriate PPE. The facility policy titled Enhanced Barrier Precautions Protocol revised April 8, 2024 documents Personal Protective Equipment (PPE) of gloves and gown should be used during high-contact resident care activities such as wound care. |