

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145772	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/26/2025
NAME OF PROVIDER OR SUPPLIER Odd Fellow-Rebekah Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to acquire, obtain, provide, and dispense prescribed medications for one resident (R3) of three reviewed for medications on a sample list of three. Findings include: R3's Census Detail dated 11/25/25 documents that R3 was originally admitted to the facility on [DATE]. R3's Medical Diagnoses List dated 11/25/25 documents that R3's medical diagnoses include symptomatic epilepsy with complex partial seizures, other seizures, hyperlipidemia, depression, history of cerebral infarction (stroke), Parkinson's disease, and hydrocephalus with a cerebrospinal fluid drainage device. R3's Physician Order Sheet (POS) dated 11/25/25 documents that R3 was prescribed Levetiracetam liquid in a strength of 100 milligrams (mg) per milliliter and was to receive 10 milliliters for a total of 1,000 mg twice daily for seizures. This same POS documents that R3 was prescribed Carbidopa-Levodopa 25-100 mg four times daily for Parkinson's disease. This same POS documents that R3 was prescribed Fluoxetine 10 mg daily for depression. This same POS also documents that R3 was prescribed Atorvastatin 40 mg daily for hyperlipidemia. R3's Medication Administration Record (MAR) for September 2025 documents that R3's Levetiracetam anti-seizure medication was not administered for either of the two doses on 9/18/25, with a special code of 7, indicating to see the nurses' progress notes for that date. R3's Nurses' Progress Notes dated 9/18/25 document that R3's anti-seizure medication Levetiracetam was on order. R3's MAR for September 2025 documents that R3's Atorvastatin (hyperlipidemia medication) was not administered on 9/14/25 with a special code of 7, indicating to see the nurses' progress notes. This same MAR documents that R3's Fluoxetine (antidepressant medication) was not administered on 9/14/25 with the same special code 7. This same MAR further documents that R3's Carbidopa-Levodopa (Parkinson's medication) was not administered for two doses on 9/29/25 with the special code 7. R3's Nurses' Progress Notes dated 9/14/25 document that R3's Atorvastatin and Fluoxetine were not available, were not in the medication storage room, and were not in the medication cart. R3's Nurses' Progress Notes dated 9/29/25-one entered at 12:03 p.m. and a second entered at 3:53 p.m.-document that R3's Carbidopa-Levodopa was on order. R3's MAR for October 2025 documents that R3's Levetiracetam anti-seizure medication was not administered for either of two doses on 10/3/25 and for the morning dose on 10/21/25, with a special code of 7, indicating to see the nurses' progress notes for those dates. R3's Nurses' Progress Notes dated 10/3/25 document that R3's anti-seizure medication Levetiracetam was not available for either of the two doses on 10/3/25. R3's Nurses' Progress Notes dated 10/21/25 document that R3's anti-seizure medication Levetiracetam was on order. On 11/25/25 at 2:48 p.m., V2, Director of Nursing, stated that the reordering process is supposed to work as follows: when any medication supply reaches 3 to 5 doses remaining, the nurse on duty is supposed to click a button in the computer for that medication, which automatically sends a note to the pharmacy to reorder the medication. On 11/26/25 at 9:48 a.m., V2, Director of Nursing, stated that there is a back-up procedure if a resident runs out of a needed medication. The nurse can call the regular pharmacy provider, which has an on-call service available 24 hours per day; however, the on-call service might be located in California. V2 further stated that (continued on next page)		

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the on-call service would call area pharmacies to locate one able to fill the needed medication. V2 additionally stated that if a resident is out of a medication, they typically only need one or two doses before the regular pharmacy delivery arrives, making it difficult to find a pharmacy willing to fill an order for one or two pills, especially if the facility is not a regular customer. V2 concluded by stating that the special on-call delivery might still take up to 12 hours, at which point it would be just as effective to wait for the regular daily pharmacy delivery.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident was free from a significant medication error involving an anti-seizure medication. This failure affected one resident (R2) out of three reviewed for anti-seizure medications on the sample list of three. Findings include: R2's Census Detail dated 11/25/25 documented that R2 was admitted to the facility on [DATE]. R2's Medical Diagnoses List dated 11/25/25 documented that R2's medical diagnoses included epilepsy. R2's Physician Prescription Facsimile from the neurologist (V6), dated 9/22/2025, documented an order for R2 to take two tablets of Keppra 250 milligrams (mg) by mouth twice a day, totaling 500 mg twice daily. R2's Physician Order Sheet entry dated 6/12/2024 documented an order for R2 to receive Levetiracetam oral tablets, 250 mg, to be given by mouth twice a day. On 11/25/2025 at 11:45 a.m., V3, Licensed Practical Nurse, stated she gave R2 one tablet of Keppra 250 mg that morning during her medication administration pass. V3 verified the order in R2's Medication Administration Record (MAR) as one tablet of Keppra 250 mg by mouth twice a day. On 11/25/2025 at 11:55 a.m., a bubble pack of Keppra 500 mg was observed for R2, documenting that one 500 mg tablet was to be given by mouth twice a day. The bubble pack was retrieved from the medication cart by V3. Handwritten on the medication bubble pack was 1/2 tab. V3 stated that 1/2 tab indicated one-half of a tablet was to be given at each dose, equaling a 250 mg dose twice daily. On 11/25/2025 at 12:15 p.m., R2's MAR documented that R2 had been administered Keppra 250 mg by mouth twice a day from 9/1/2025 through the morning dose on 11/25/2025. On 11/25/25 at 2:48 p.m., V2, Director of Nursing, confirmed that the most recent physician order from the neurologist (V6) was for Keppra 250 mg with instructions to administer two 250 mg tablets twice daily, for a total of 500 mg twice daily. V2 stated the facsimile did not have a signature from facility nursing staff and the document must have been uploaded into R2's electronic medical record prior to the nurses transcribing the new order onto R2's Physician Order Sheet. V2 confirmed that the current dose should be 500 mg twice daily.		