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	02/20/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview, and record review the facility failed to protect the resident's right to be free from physical abuse by another resident. This failure affects two (R4, R6) of three residents reviewed for abuse in the sample list of 7. This failure resulted in R4 sustaining a fracture to her right wrist.Findings include:R4's health status note dated 12/27/25 documents that R4 allegedly had a physical altercation with another resident that resulted in R4 falling to the ground and sent to the emergency room for evaluation.R4's event note dated 12/28/25 documents that R4 was pushed by another resident (R6).R4's progress notes dated 12/28/25 documents R4 returned to the facility form the emergency room with a soft cast to her right hand due to a fracture.On 2/19/26 at 11:50 a.m., V4, Licensed Practical Nurse (LPN) stated that on the night of 12/27/25 she was passing pills when V15 Certified Nurse Assistant (CNA) told her that R4 was on the floor because another resident (R6) pushed R4. V4 stated she went to check on R4 and observed her on the floor by the nurse station close to the fireplace. V4 attempted to assess R4 but R4 refused and demanded to be sent to the hospital. V4 stated she sent R4 to the hospital for evaluation per physician's order and notified R4's family. V4 stated she notified V1 about the incident between R4 and R6. V4 stated R4 provoked R6 that may have led to pushing. V4 stated that R4 returned to the facility the next morning with a soft cast to her right hand.R4's Care Plan dated 8/14/25 documents that R4 exhibits verbal behaviors such as yelling and threatening others. R6's Care Plan dated 4/15/24 documents that R6 experiences episodes of impaired moods/behaviors. This Care Plan documents that R6 has physical behaviors such as hitting others, swinging purse at others, throwing things, attempting to break windows, and flashing others. On 2/19/26 at 10:53 a.m., R4 was observed sitting in a chair in the common area with a platform walker positioned in front of her. R4 had a wrist brace applied to her right hand. R4 stated that her hand was broken because she interfered in a fight, stating, I got the worst of it. R4 stated she does not remember when the fight occurred. R4 stated she was pushed but was unable to identify who pushed her.On 2/20/2026 at 11:28 a.m., V15, CNA stated she was present when the incident occurred between R4 and R6 on 12/27/25. V15 stated she did not witness how the alleged altercation started but when she turned around, she witnessed R6 push R4 causing R4 to fall to the ground. V15 stated they separated both residents and reported the incident to the nurse. V15 stated she wrote a statement regarding the incident on 12/27/25 and gave it the nurse.R4's Electronic Medical Record (EMR) documents an X-ray result dated 12/28/25, which showed that R4 sustained a shattered and displaced wrist fracture (distal radius) as a result of her fall.

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report to the state an allegation of resident-to-resident abuse for two (R4, R6) out of three residents reviewed for abuse, on a sample list of seven.Findings include:The facility's abuse prohibition policy with revision date of 1/29/2026 documents if the incident involves alleged abuse, the incident will immediately be reported to the Administrator and the Administrator shall provide the Illinois Department of Public Health with initial notice of the alleged abuse via OHCR Portal or by emailing or telefaxing to the Department a copy of a report of the incident completed immediately after the incident becomes known. Administrator shall report alleged violations of abuse or if there is resulting serious bodily injury, immediately, but no later than two hours after the allegation was made. R4's health status note dated 12/27/25 documents that R4 allegedly had a physical altercation with another resident and resulted that resulted in R4 falling to the ground and being sent to the emergency room for evaluation. R4's Electronic Medical Record (EMR) contains an event note dated 12/28/25 that documents R4 was pushed by another resident. R4's progress notes dated 12/28/25 documents R4 returned to the facility with a soft cast to her right hand due to a wrist fracture following the incident.R4's health status note dated 12/28/25 at documents that V4 notified V1 Administrator about the incident. On 2/19/26 at 11:50 a.m., V4 Licensed Practical Nurse (LPN) stated she called V1 Administrator and reported the incident. On 2/20/25 at 3:00 p.m., V1 Administrator stated he did not notify the State Agency about the incident involving R4 and R6. V1 Administrator stated that he should report all allegation of abuse incidents.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review the facility failed to investigate allegations of resident-to-resident physical abuse for two (R4, R6) out of three residents reviewed for abuse, on a sample list of seven. Findings include:The facility's abuse prohibition policy with revision date 1/29/2026 documents after an initial report of suspected abuse or neglect is sent to IDPH, the Administrator or designee shall investigate all alleged incidents of abuse. R4's health status note dated 12/2/25 documents that R4 allegedly had a physical altercation with another resident and resulted for R4's to fall that required sending her to the emergency room.R4's progress note dated 12/28/25 documents R4 returned to the facility with a soft cast to her right hand due to a fracture following the incident. R4's event note dated 12/28/25 documents that R4 as pushed by another resident.R4's health status note dated 12/28/25 documents V4 Licensed Practical Nurse (LPN) notified V1 Administrator following the incident between R4 and R6.V4, LPN stated she called V1, Administrator to report the incident on the day it occurred.On 2/20/26 at 3:00 p.m., V1, Administrator stated he did not investigate the incident. V1 Administrator stated he should investigate all alleged abuse that is reported to him.

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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** Based on observation, interview, and record review, the facility failed to provide adequate supervision and implement care plan interventions for a resident who required her bed to be maintained in the lowest position when in bed. This failure resulted in a fall for one (R3) of three residents reviewed for accidents. R3 sustained soft tissue swelling around the left eye and a 2-centimeter (cm) laceration above left eyebrow, requiring emergency room treatment and wound closure with adhesive glue. Findings Include:The facility's Fall Assessment and Management Policy dated 11/30/2012 with a revision on 6/2024 documents that it is the policy of the facility to 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. Factors related to the risk will be addressed and care planned.This policy documents that based on the results of the Fall Risk Assessment, the potential for falls will be carefully addressed through individualized planning. The interdisciplinary care plan will be person-centered, reflecting the resident's unique needs, preferences, and identified risk factors. All staff members responsible for providing care will have access to the care plan and/or Kardex to ensure consistency and continuity in implementing fall prevention strategies.This policy documents that interventions will be based on the fall risk assessment and the circumstances surrounding the risk for injury or actual injury or fall. Some examples may be: Falls related to gait/balance deficit.Falls related to confusion.Falls related to position problems.Falls related to toileting needs.Falls related to syncopal episodes.Falls related to environmental hazards.Falls related to sensory/perceptual problems.Falls related to poor judgement or knowledge deficit. R3's Minimum Data Set (MDS) dated [DATE], documents R3 has Unspecified Dementia with agitation. This MDS also documents that R3 requires substantial/maximal assistance from staff when getting from a lying to sitting on side of bed and a sitting to lying position.R3's Electronic Medical Record (EMR) contains a fall assessment dated [DATE] documents that R2 is at high risk for falling.R3's care plan dated 05/15/2025 documents that R3 is at risk for falls due to unsteady gait, poor balance, and generalized weakness. Interventions implemented to address this risk include maintaining R3's bed in the lowest position.R3's incident investigation report dated 1/11/26 documents that R3 requires staff assistance with transfers and was observed on the floor of her room. This report documents that R3 had been sitting on the edge of the bed preparing to get up for the day when R3 scooted forward off the bed as aide was preparing to assist R3 into the wheelchair. R3 landed in a sitting position on the floor and as her Torso went forward, she bumped her head on the floor.On 02/19/2026 at 10:38 a.m., R3 was observed seated in her wheelchair adjacent to the nurses' station, leaning noticeably to one side while sleeping.On 2/19/26 at 1:19 p.m., V7, Certified Nurse Assistant (CNA), stated she was caring for R3 on the day of R3's fall from her bed on 1/11/26. V7 stated she entered R3's room and raised the bed from its lowest position to assist with dressing and preparing the resident to get up for the day. V7 stated she helped R3 to a sitting position on the edge of the bed, then laid R3 back down to retrieve clothing from the bedside table. V7 stated that while her back was turned to gather the clothing, she heard a sound and realized R3 had fallen. V7 stated the resident appeared to have slid off the bed, landing on her buttocks and then falling forward, striking her head on the floor. V7 confirmed R3's bed was in its normal position, approximately two feet from the floor. On 1/19/26 at 11:40 a.m., V6, Licensed Practical Nurse (LPN), stated she was the nurse caring for R3 on the day of the fall, 01/11/2026. V6 stated V7, CNA, came and got her when the incident occurred. V6 stated that V7 reported that R3 was sitting on the edge of the bed when V7 turned to retrieve the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	mechanical lift device to transfer R3 to her wheelchair and when V7 turned back toward R3, she observed that R3 had slid off the bed, falling forward and striking her head. V6 stated she assessed R3 and noted a cut on R3's left eyebrow. V6 stated she sent R3 to the emergency room for evaluation and R3 later returned with the eyebrow repaired using adhesive glue. V6 stated R3 can sometimes be combative, particularly during transfers, and other CNAs commented to V6 that the fall was not surprising, as R3 frequently attempts to scoot off the bed. V6 confirmed that R3's bed was not in the low position when she entered the resident's room, although it is typically kept in the lowest position when the resident is in bed.On 02/20/2026 at 12:37 a.m., V2, Director of Nursing (DON), stated he would need to review R3's Care Plan; however, he stated that if the Care Plan indicated R3 required a low bed, then the CNA caring for R3 should have maintained the bed in the lowest position until she was prepared to provide care that morning. V2 stated the CNA should not have turned away from R3 while the R3 was in bed and not in a low position.R3's emergency room notes dated 01/11/2026 document that the resident's fall resulted in treatment for soft tissue swelling around the left eye and a 2-centimeter laceration above the left eyebrow.