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	04/24/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to answer call lights for residents needing assistance in a timely manner to promote dignity for one (R6) of three residents reviewed in a sample of nine. Findings include:On 4/22/2026 at 11:26 AM R6 states sometimes it can take staff 20-30 minutes to answer call lights. R6 states since admission he has had three or four incontinent episodes due to having to wait for assistance with toileting. R6 states he has now been wearing incontinent briefs due to not knowing how quickly staff will be available to assist him to the restroom. R6 states he did not wear incontinent briefs prior to being admitted to the facility.On 4/23/2026 at 9:54 AM R6 states he had an episode of bowel incontinence this morning. R6 states he is now wearing incontinent briefs all day long. R6 states if he does have an incontinent episode that staff will assist him with perineal care right away.On 4/22/2026 at 1:52 PM V15 Registered Nurse states R6 is continent if he can reach the restroom on time. V15 states R6 requires assistance of one staff member to transfer onto toilet using a walker and wheelchair. V15 states she believes R6 was continent while at home.R6's Bladder Incontinence assessment dated [DATE] documents R6 is continent of bladder.R6's bowel and bladder task documentation in his electronic health record (EHR) shows one episode of bowel incontinence and three episodes of bladder incontinence between the dates of 4/17/2026 and 4/23/2026.R6's admission progress note dated 4/17/2026 at 3:30 PM documents Abdomen flat, non-tender. Bowel sounds present x4. Denies indigestion, nausea, vomiting, diarrhea, constipation or bowel incontinence. Resident continent of bladder. Urine clear yellow. Denies urinary complaints.Grievance Complaint Report dated 12/8/2026 documents a grievance from Resident Council that call lights are on for an extended period of time before help can be given. Certified Nursing Assistants (CNA) come in, turn call light off, say they will return but never do.Grievance Complaint Report dated 1/27/2026 documents a grievance from Resident Council that Call lights are not being answered timely. Residents complained about not getting enough help.On 4/24/2026 at 10:23 AM V2 Director of Nursing states he would expect staff to answer call lights within five minutes or less, however answering in less than ten minutes during times of higher activity levels is appropriate.The Illinois Long-Term Care Ombudsman Program booklet titled Residents' Rights for People in Long-Term Care Facilities, revised on 11/2018, documents Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life.

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 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 implement a baseline careplan for one (R2) resident, failed to implement fall interventions for three (R2, R3, R4) residents, failed to ensure the safety of one (R3) resident and failed to complete comprehensive fall investigations for three (R2, R3, R4) residents out of three residents reviewed for Accidents in a sample list of ten residents. R3 obtained five sutures to her forehead and a Subdural Hematoma due to an unwitnessed fall at the facility. R3 was transported to the emergency room to undergo diagnostic testing, laboratory work and full assessments from hospital staff. R3 experienced pain due to falling off her bed that was in high position. Findings include:1.R3's Electronic Medical Record (EMR) documents that R3 was admitted to the facility on [DATE].R3's EMR documents medical diagnoses of morbid obesity, chronic congestive heart failure, atrial fibrillation, chronic obstructive pulmonary disease (COPD), restless leg syndrome, and traumatic subdural hemorrhage without loss of consciousness.R3's Physician Order Sheet (POS), dated March 2026, documents a physician order beginning 1/13/2026 to administer Warfarin Sodium (anticoagulant) 2 milligrams (mg) daily Saturday through Thursday and 1 mg every Friday. This same POS documents that R3 is to wear oxygen at 2 liters per nasal cannula continuously.R3's Minimum Data Set (MDS), dated [DATE], documents R3 as moderately cognitively impaired. This same MDS documents R3 as dependent for toileting, dressing, and transfers, and requiring maximum assistance for bathing, personal hygiene, and bed mobility.R3's Fall Risk Evaluation, dated 2/17/26, documents R3 as a high fall risk.R3's Nurse Progress Note, dated:3/10/26 at 10:45 AM, documents R3 was observed on the ground next to her bed with the bed in a high position. This same note documents V7 Licensed Practical Nurse (LPN) was completing medication administration when V7 LPN saw R3 lying on the floor next to her bed on her stomach, unclothed, and with blood on the floor. This same note documents R3 stated she did not know how she got there but did not roll out of bed. This same note documents R3 had a hematoma with a laceration on the right side of her forehead above the brow bone, and scattered bruising noted more prominently on her right arm after her fall.3/10/26 at 5:45 PM, documents R3 was admitted to the hospital with diagnoses of fall and urinary tract infection (UTI). This same note documents R3 received five sutures to the forehead laceration. This same note documents R3's X-ray reads possible fractures of the ninth and tenth ribs, and the physician notes document actual fractures.3/17/26 at 2:01 PM, documents staff removed five sutures from the right side of R3's forehead.R3's Hospital Record, dated 3/10/26, documents R3 had an unwitnessed fall with unknown down time on 3/10/26, resulting in a right forehead abrasion, a 4 centimeter (cm) long by 2 millimeter (mm) deep laceration to her right forehead, right elbow and right lateral ankle abrasions, right leg and right elbow skin tears, and bruising to bilateral forearms. This same record documents R3's computerized tomography (CT) scan of her head was initially read as nothing acute and then was updated at 1521 to demonstrate a 3 millimeter (mm) right parietal subdural hematoma, which did appear acute.R3's Chest X-ray, dated 3/10/26, documents possible ninth and tenth rib fractures.R3's Fall Investigation, dated 3/10/26, does not document whether R3 was wearing her physician-ordered oxygen. R3's fall investigation does not document how R3's bed was in a high position, when R3 was last observed, or what fall interventions were in place.R3's Final Report to the State Agency, dated 3/17/26, documents R3 had an unwitnessed fall on 3/10/26 resulting in five sutures to the right forehead and a subdural hematoma caused by the fall. This same report documents R3's bed was found in a high position.On 4/23/26 at 9:35 AM, R3 was placed in her room by V7 Licensed Practical Nurse (LPN). R3 stated she remembers falling on 3/10/26. R3 stated, Boy! That hurt! I had a headache for days. My bed was as high as the clouds. That is why it hurt so bad.On 4/23/26 at 9:47 AM, V7 Licensed Practical Nurse (LPN) stated she was R3's nurse on 3/10/26. V7 LPN stated she got report at 6:00 AM, prepared for the day, and then started down the hall to begin (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	passing medications. V7 LPN stated she entered R3's room to administer medications to R3's roommate. V7 LPN stated R3's curtain was pulled around her bed, but she heard R3 faintly say, Help me. V7 LPN stated when she pulled R3's curtain back, she could see that R3 was lying on her stomach, not wearing any clothes, and the bed sheet was lying on the floor. V7 LPN stated R3's call light was attached to her side rail and out of her reach. V7 LPN stated R3's room was dark. V7 LPN stated R3 had a pool of blood around her head. V7 LPN stated R3's bed was at chest-level height. V7 LPN stated R3 stated she was trying to sit herself up but clearly didn't make it. V7 LPN stated R3 had been there a long time based on R3's appearance and the look of her injury.On 4/23/26 at 10:00 AM, V24 Certified Nurse Aide (CNA) stated when V24 entered R3's room, R3 was not wearing any clothes. V24 CNA stated R3 was lying with her head underneath the bed and her feet facing toward the room door. V24 CNA stated R3 was lying in a lot of blood. V24 CNA stated R3's bed was in the highest position it could go.On 4/23/26 at 10:20 AM, V23 Agency Certified Nurse Aide (CNA) stated she arrived at work at 6:00 AM on 3/10/26 and was assigned to R3's hallway. V23 CNA stated she received a verbal report from V25 CNA, who stated everyone is fine. V23 CNA stated she prepared for her shift and started getting other residents up first. V23 CNA stated she had not entered R3's room until V7 Licensed Practical Nurse (LPN) asked her to help assist R3 after she fell. V23 CNA stated when she entered R3's room, R3 had dried blood on her forehead and was lying in a puddle of blood on the floor with her bed in the highest position it could go. V23 CNA stated R3's bed should not have been in such a high position because it is dangerous for the residents. V23 CNA stated it appeared that R3 had not been checked on for a long time. 2. R4's Care Plan, initiated 2/9/26, documents medical diagnoses of repeated falls, glaucoma, dementia, Parkinson's disease, abnormalities of gait and mobility, and abnormal posture. This same Care Plan documents fall interventions, dated 3/2/26, instructing staff to use anti-rollback brakes on R4's wheelchair.R4's Minimum Data Set (MDS), dated [DATE], documents R4 as severely cognitively impaired. This same MDS documents R4 as requiring maximum assistance for toileting and moderate assistance for dressing, bed mobility, and transfers.R4's Fall Risk Evaluation, dated 2/27/26, documents R4 as a high fall risk.R4's Nurse Progress Note, dated 3/30/26 at 2:22 PM, documents R4 attempted to stand and ambulate herself when she slid out of her wheelchair and onto the floor.R4's Fall Investigation for the 3/30/26 fall documents R4's anti-lock brakes needed reassessment. This same fall investigation does not document when R4's wheelchair had been assessed for safety or whether it was functioning properly.On 4/22/26 at 11:40 AM, V16 Agency Licensed Practical Nurse (LPN) stated she was R4's nurse and was not aware of any fall interventions for R4. V16 agency LPN demonstrated she was not able to open R4's care plan to access R4's fall interventions. V17 Restorative Nurse/Fall Nurse showed V16 how to access resident fall interventions in the resident care plan. V16 agency LPN stated, Oh thank you. Now I know how to do that. That is good to know.On 4/24/26 at 10:05 AM, V28 Environmental Services Director stated the facility has a computer system staff use to input work orders. V28 stated the system is reliant on what staff enter as the problem. V28 stated staff may enter wheelchair brakes, but that does not tell V28 what is wrong with the brakes. V28 stated the facility does not have a tracking system showing what was fixed on any given piece of equipment. V28 stated the system only allows staff to enter whether the work order was completed, not the actual work that was done. V28 stated there is really no way to tell what was done to any piece of equipment. V28 Environmental Services Director stated R4's anti-rollback brakes needed readjustment because R4's wheelchair was sliding back. V28 stated R4's anti-lock brakes were assessed on 3/31/26 and found to be not functioning properly. V28 stated R4's anti-lock brakes were readjusted on 3/31/26.On 4/24/26 at 10:35 AM, V29 Maintenance Assistant confirmed he worked on R4's anti-lock brakes. V29 stated the work order documents the work order was completed. V29 stated he does not remember whether the anti-lock brakes were loose or out of alignment, but that there was something wrong with them for me to work on them. V29 stated he adjusted R4's brakes and completed the work order. V29 confirmed he fixed R4's anti-lock brakes on 4/1/26.On 4/24/26 at (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	9:25 AM, V11 Licensed Practical Nurse (LPN) stated V26 Activity Aide was sitting with R4 when she fell on 3/30/26. V11 stated R4 stood up and then went to sit down when her wheelchair rolled back, causing R4 to fall to the floor. V11 LPN stated R4 was not injured. V11 stated R4's anti-rollback brakes did not work. V11 stated the intervention put into place was a non-skid mat to be placed in R4's chair because R4 slid out of her wheelchair as she was trying to sit back down. V11 stated the anti-rollback brakes were already an intervention but did not work.On 4/24/26 at 9:35 AM, V26 Activity Aide stated she had been sitting with R4 on 3/30/26 in the activity room when R4 fell. V26 stated she left R4's side to assist another resident when R4 stood and fell. V26 stated R4's wheelchair had anti-lock brakes in place, but they were broken because the wheelchair rolled back when R4 went to sit back down. 3. R2's undated Face Sheet documents R2 was admitted to the facility on [DATE] with medical diagnoses of dementia, abnormal posture, unsteady gait, traumatic subdural hemorrhage, and neurocognitive disorder with Lewy bodies.R2's Minimum Data Set (MDS), dated [DATE], documents R2 as moderately cognitively impaired. This same MDS documents R2 as requiring supervision with transfers.R2's Fall Risk Assessment, dated 3/6/2026, documents R2 as a high fall risk.R2's Electronic Medical Record (EMR) does not document a Baseline Care Plan.R2's Fall Investigation, dated 3/12/26, documents R2 had a witnessed fall after walking independently in the hallway and tripping over a total body mechanical lift, hitting her face/left cheek on the lift. This same investigation documents R2 voiced pain in her right hip/pelvic area with external rotation of the right leg when lying flat on her back. This same report documents R2 was sent to the emergency room. This same report documents V19 Assistant Dietary Manager saw R2 ambulating independently in the hallway, said Hi to R2, and then R2 fell, landing on the leg of the lift. This same report documents the root cause of R2's fall was that R2 turned around and lost balance.On 4/22/26 at 12:08 PM, V18 Certified Nurse Aide (CNA) stated she would look in the Kardex to find safety interventions for a resident. V18 CNA demonstrated she could not gain entry to a facility computer. V18 CNA stated she does not ever use the computers on the halls to chart or see safety interventions. V18 CNA stated she completes all charting after her shift is done in the break room. V18 CNA stated if there were a new safety/fall intervention put in place for any resident, she would not know what it was until after her shift was completed.On 4/24/26 at 12:00 PM, V2 Director of Nurses (DON) stated the fall investigations for R2, R3, and R4 were all incomplete because the investigations lacked key pieces of information pertaining to the residents' falls. V2 DON stated R2's fall investigation should have included information about when R2's needs were last met because she was wandering the halls; R3's fall investigation should have included information about when R3's needs were last met and who placed R3's bed in a high position; and R4's fall investigation should have included who last visualized R4 and whether the fall interventions were in place. V2 DON stated fall interventions should be in place. V2 DON stated R2 did not have a baseline care plan in place for any areas of focused care. V2 DON stated the facility is to complete a baseline care plan for all areas of concern for the resident and then complete a thorough care plan at a later date. V2 DON stated staff would not know what the fall interventions were for R2 if the care plan were not in place. V2 DON stated there should have been an intervention put into place after R2's fall on 3/11/26 and again after her fall on 3/12/26. V2 DON stated R2's falls had different causes, but the care plan should have been in place. V2 DON stated staff are to offer/provide incontinence care every two hours on the even hours. V2 DON stated there is no documentation and/or staff able to report that R3 was visualized between 4:00 AM and 6:55 AM when she was found on the floor. V2 DON stated staff are allowed to raise resident beds during care, but then they should lower them back down to their care-planned height. V2 DON stated R3 was not care planned to be in a low bed, but that her bed position should have been the standard height, about knee height, from the floor. V2 DON stated the facility is not able to provide any documentation or staff reports of R3 ever raising the bed herself, so V2 DON assumes staff left R3's bed in a high position. V2 DON stated R4 was on rounds every 15 minutes, but the facility does not have any documentation the frequent visual checks were completed. V2 DON stated there is an alert system (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	that rings to V2's phone and then V1 Administrator's phone if the call light has been activated too long, but there is no documentation showing staff visually checked the resident. V2 DON stated due to R4's fall on 3/30/26, the facility will now complete monthly visual checks on all resident wheelchairs to ensure they are working properly. V2 DON stated R4's non-skid mat in her wheelchair should be placed on top of and underneath her wheelchair cushion. V2 DON stated the facility did not directly cause the resident falls, but staff should ensure all fall interventions are in place.On 4/24/26 at 2:10 PM, V30 Nurse Practitioner (NP) stated the facility does need to document the conditions of falls and condition changes more thoroughly. V30 NP stated R4 would not have been able to pull the privacy curtain by herself. V30 NP stated basic nursing training includes checking on residents at least every two hours. V30 NP stated she has not reviewed the fall investigations directly but was informed by the facility of resident falls. V30 NP stated the facility did not directly cause injuries, but fall interventions should have been in place and functional, and residents should have been checked on at least every two hours.The facility Fall Assessment and Management policy, revised June 2024, documents the potential for falls will be care planned based on the results of the fall assessment. All staff providing care for the resident shall have access to the resident care plan.