

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

Printed: 08/27/2026
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 06/16/2026
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 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 ensure one resident (R1) was free from physical abuse from another resident (R2). This failure caused R1 to sustain a nasal fracture, a facial laceration requiring sutures to close, and bilateral hematomas to her eyes. Findings Include: R2's Care Plan, updated 6/16/26, includes the following diagnoses: Dementia, Hypertension (HTN), Hyperlipidemia, Pseudobulbar Affect, Seizure Disorder, and Aneurysm of the Aortic Arch. The Care Plan includes a problem initiated on 1/14/25 documenting that R2 has physical behavioral symptoms, including pulling others' hair, shoving or hitting others, and throwing items at others. The Care Plan also documents verbal behavioral symptoms, including yelling and growling at others. Additional behavioral symptoms include packing belongings, placing herself on the floor, urinating in inappropriate places, pacing, slamming or banging on doors, peeking around corners, and rummaging. The Care Plan further documents that R2 experiences delusions, including believing others are taking her money, and hallucinations, including seeing, talking to, or arguing with people who are not present. R1's Care Plan, updated 5/10/26, includes the following diagnoses: Alzheimer's Disease, Dementia, Osteoarthritis, Hypothyroidism, Chronic Kidney Disease, Hyperlipidemia, and Idiopathic Chronic Gout. The Care Plan includes a problem initiated on 8/21/25 documenting that R1 experiences episodes of impaired mood and behaviors. These behaviors include verbal symptoms such as yelling, screaming, swearing, and mocking; other symptoms such as hitting her chest and slamming her fists; physical symptoms including hitting and slapping others; and delusions, including the false belief that her daughter broke into her house and stole her belongings. The Facility Census dated 6/15/26 documents that both R1 and R2 resided in the facility's memory care unit. On 6/15/26 at 11:00 a.m., R1 was observed sitting at a table in a common area with other residents. R1 had purple-to-yellow bruising around both eyes and a new scar on her chin where sutures had recently been removed. When asked if she remembered how she sustained the bruising and chin wound, R1 stated, That's all over and it's just a lot of B.S. (expletive), and we can talk about something else. At the same time, R2 was observed sleeping quietly in her bed at the opposite end of the memory care unit. The facility's Final Report to the State Agency, dated 5/26/26, documents: (R2), who is alert and confused, ambulates and transfers independently, and has a BIMS (Brief Interview for Mental Status) score of 0, indicating severe cognitive impairment, was observed entering the doorway of the South Harmony Unit. R2 was slapping hands and arguing with (R1), who is alert and oriented to person only, ambulates and transfers independently, and has a BIMS score of 5. R1 was observed being pushed, causing her to lose her balance and fall to the floor. The interaction was observed by staff, and the residents were immediately separated. The resident who fell was immediately assessed and noted to have a laceration to her chin, bruising to her nose, and blood in her mouth. The Administrator, physicians, and Power of Attorney were notified. A new order was received to send R1 to the local hospital emergency department for evaluation and treatment. Emergency Medical Services (EMS) arrived and transported R1 to the emergency department, where she was diagnosed with a nasal fracture and received sutures to close the chin laceration. R1 returned to the facility with orders to remove the sutures in 7 to 10 days. No additional orders were received. The residents were kept separated, and (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
--	-------	-----------

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 06/16/2026
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 0600 Level of Harm - Actual harm Residents Affected - Few	no further incidents occurred. On 6/16/26 at 11:15 a.m., V8, Memory Care Plan Coordinator/LPN, verified that, prior to the altercation, unit staff were aware that both R1 and R2 had histories of physical altercations with other residents and that behavioral care plans were in place addressing these and other behaviors. On 6/16/26 at 11:30 a.m., V10, Memory Care Director, verified that when a resident has a known history of physical altercations, it is her expectation that staff take all reasonable measures to ensure those residents are kept a safe distance from other residents with similar histories whenever possible. V10 further verified that R1 and R2 were allowed to remain in close proximity to one another and that, as a result, R1 sustained injuries. The facility's Abuse and Neglect Policy, revised 1/29/26, states: All residents have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, neglect, misappropriation of property, and exploitation. This includes freedom from physical or chemical restraints not required to treat the resident's symptoms. The policy further defines abuse as: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse includes deprivation by an individual, including a caretaker, of goods or services necessary to attain or maintain physical, mental, or psychosocial well-being. Willful means the individual acted deliberately, not necessarily with the intent to inflict injury or harm. The policy defines physical abuse as: The infliction of injury on a resident that occurs other than by accidental means and requires (whether given) medical attention. Physical abuse may include, but is not limited to, hitting, slapping, kicking, hair pulling, and pinching. The policy further states: When an allegation of suspected abuse is received involving another resident as the alleged perpetrator, that resident's condition shall be immediately evaluated to determine the most appropriate therapy and placement, considering the safety of that resident as well as the safety of other residents and employees. If the incident involves suspected resident-to-resident abuse, the Administrator shall take all steps necessary to protect all residents in the facility from abuse until the allegation has been investigated.		