

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0010223		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/20/2026	
NAME OF PROVIDER OR SUPPLIER ODD FELLOW-REBEKAH HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 201 LAFAYETTE AVENUE EAST , MATTOON, Illinois, 61938			
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S0000	Initial Comments		S0000			03/03/2026	
	Investigation of Facility Reported Incident of 1/11/26-2729897						
	Complaint Investigation - 2660418/2713189						
S9999	Final Observations		S9999			03/03/2026	
	Statement of Licensure Violations: (1 of 2)						
	300.610a)						
	300.1010h)						
	300.1210b)						
	300.3210t)						
	Section 300.610 Resident Care Policies						
	a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility.						
	Section 300.1010 Medical Care Policies						
	h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These regulations were not met as evidence by: 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 from 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			S9999			

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S9999	Continued from page 2 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. (B) (2 of 2) 300.610a) 300.1010h)			S9999			

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S9999	Continued from page 3 300.1210b) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. These regulations were not met as evidence by: 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	S9999					

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S9999	Continued from page 4 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 2/9/26, 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 11/16/25 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			S9999			

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S9999	Continued from page 5 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 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		S9999				

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S9999	Continued from page 6 (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. (B)			S9999			