STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145480	A. Building B. Wing	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mattoon Rehab & Hcc	2121 South Ninth 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 - Some

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 42702

Based on interview and record review the facility failed to ensure the dignity of four (R1, R12, R13 and R14) of six residents reviewed for dignity from a total sample list of 15 residents.

Findings include:

1.) The facility provided report to the State Agency dated 11/26/24 documents that on 11/19/24, R1 complained that he did not like the care provided to him by V15 Certified Nursing Assistant (CNA). The facility response documented that V15 CNA would not provide R1 with further care.

R1's Minimum Data Set, dated dated dated [DATE] documents R1 as cognitively intact and that R1 is dependent on staff for activities of daily living.

On 12/16/24 at 10:00AM, V15 CNA stated that he continues to provide care for R1, as directed by the nursing staff.

On 12/16/24 at 1:00PM, R1 stated that V15 CNA still cares for him. R1 stated, They just do whatever they want.

On 12/16/24 at 3:10PM, V1 Administrator stated that V15 CNA is not supposed to be providing care for R1 and that by doing so, R1's wishes are being disrespected.

2.) The facility provided report to the State Agency dated 11/15/24 documents that R12 complained that while in her room, V13 (Roommate's Boyfriend) walked in on her in a state of undress and did not immediately leave.

R12's Minimum Data Set, dated dated dated [DATE] documents R12 is cognitively intact.

R12's progress notes document discharge from the facility on 12/1/24.

On 12/16/24 at 8:15AM, V14 CNA stated that she was in the area when the issue occurred and that she got to R12 as soon as R12 began to yell and removed V13 from the room. V14 CNA stated that she was able to calm R12 after that. V14 stated that nothing like that had ever occurred in the facility before, to her knowledge.

(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: 145480	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mattoon Rehab & Hcc	2121 South Ninth Mattoon, IL 61938

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/16/24 at 9:15AM, V12 Social Services Director stated that she met with R12 multiple times after the incident and that R12 returned to her baseline. In the moment, R12 was very upset and embarrassed and I'm sure it was a dignity issue for her. 3.) The facility provided report to the State Agency dated 12/4/24 documents that on 11/26/24, R13 complained that R13 was disrespectful to her by not being responsive to her needs. The facility response dated 12/4/24 documents that V4 CNA will not be providing further care for R13. R13's Minimum Data Set, dated dated dated [DATE] documents that R13 is cognitively intact. On 12/16/24 at 10:46AM, R13 stated that there is a CNA on nights who just isn't kind. R13 then described V4 CNA, confirmed by V16 LPN. I would ask her to get something for me and she would say, Its just right there. I would definitely say that she was disrespectful. On 12/16/24 at 10:50AM. R13 confirmed that V4 CNA continues to provide her with care. 4.) The facility provided report to the State Agency dated 12/6/24 documents that on 11/30/24 R14 complained that V18 and V19 CNAs were providing R14 with care while laughing and being rude to R14. R14's Minimum Data Set, dated dated dated [DATE] documents R14 as cognitively intact. R14's Minimum Data Set, dated dated dated [DATE] documents that R14 is dependent on staff for mobility and toileting. On 12/16/24 at 12:01 PM, R14 stated that she had an issue with 2 CNAs recently when she needed to use the restroom and the CNAs came in and started laughing while assisting her with moving her on the lift and to toilet. It was so weird, both my roommate and I asked why they were laughing and they said that it wasn't about me but I didn't believe them. I definitely felt bad and disrespected. On 12/12/24 at 12:00PM, V1 Administrator stated that V18 and V19 CNA's are on the do not hire list because of the complaint.

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NAME OF PROVIDER OR SUPPLIER Mattoon Rehab & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE 2121 South Ninth Mattoon, IL 61938	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 42702 Based on interview and record review the facility failed to complete a thorough investigation for one (R1) of six residents reviewed for abuse from a total sample list of 15 residents. Findings include: The facility provided Abuse Policy dated 12/2024 documents that the facility Administrator will ensure a thorough investigation of alleged violations of individual rights and document appropriate action. Steps in the investigation include completing a thorough investigation with two management level staff conducting interview with witnesses or other staff, residents or visitors who could have knowledge of the allegation and witnesses will be asked to assist with completing statements. Every employee will be interviewed who was working on the specific hall/wing that the affected resident resides on and if the allegation occurred on a specific shift, all staff for the identified shift only will give a statement if indicated. The facility will immediately remove any alleged perpetrator from any further contact with any resident through suspension, pending the outcome of the facility investigation, prosecution, or disciplinary action against the employee. At the time of suspension, the alleged perpetrator will be interviewed. The facility provided report to the State Agency dated 12/1/24 documents that on 11/25/24 R1's left hand was bruised. An X-ray was performed on 11/25/24 and found the third finger was fractured. According to the facility report, this injury occurred while an unnamed Certified Nursing Assistant (V20 CNA) was dressing R1. The facility investigation report was reviewed for a thorough and complete investigation. No interviews with V20 CNA were obtained. No interviews about V20's care with other residents or customer service were completed with residents or other staff members. V20 CNA's time cards were reviewed. V20 worked at the facility on 11/23/24, 11/24/24, 11/25/24 and on 12/8/24. On 12/16/24 at 11:30AM, V1 Administrator stated that nursing did the investigation of R1's finger injury. On 12/16/24 at 1:15PM, V2 Director of Nursing stated that she didn't investigate who might have injured R1's finger. I just missed it. I was off site and trying to do a bunch of things and just took his word for the fact that it was not an unknown injury and didn't think about it potentially being abuse. I should have asked more questions. V20 CNA was not suspended. On 12/16/24 at 3:30PM, V1 Administrator stated that V20 CNA will no longer be employed at the facility through the employment agency where she was working and that moving forward, V1 will review all investigations for thoroughness and completion.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42702 Based on observation, interview and record review the facility failed to provide nail care for one of six residents (R1) reviewed for activities of daily living from a total sample list of 15 residents. Findings include: The facility provided report to the State Agency dated 11/26/24 documents that on 11/25/24 a bruise was found on R1's left middle finger and upon X-ray was fractured. The facility report documents the cause of the fracture was due to R1's cracked fingernail snagging his shirt causing the finger to be bent and fractured while R1 was dressed due to left side hemiplegia. R1's care plan dated 11/26/24 documents to keep R1's nails trimmed and short enough to prevent snagging on clothing. R1's Minimum Data Set, dated dated dated [DATE] documents R1 as cognitively intact and that R1 is dependent on staff for activities of daily living. On 12/12/24 at 11:45AM, R1's nails on both the right and left hands were nearly an inch past the end of the finger with food and brown matter underneath them. On 12/16/24 at 9:30AM, R1's nails remained long on both hands (nearly an inch past the end of the fingers) with food and brown matter underneath them. On 12/16/24 at 9:31AM, R1 stated that he would like to have his nails clipped.