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 12/23/2025

NAME OF PROVIDER OR SUPPLIER Mattoon Rehab & Hcc	STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for 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. (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

FORM CMS-2567 (02/99)
Previous Versions Obsolete

Event ID:

Facility ID:

145480

If continuation sheet
Page 1 of 2

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review the facility failed to protect the resident's right to be free from verbal abuse by a visitor. This failure affects one (R3) of four residents reviewed for abuse in the sample list of four. Findings include: The facility's Abuse, Prevention and Prohibition Policy dated November 2025 documents that each resident has the right to be free form abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, friends, or other individuals. This policy documents that when individuals other than employees are the alleged perpetrators, those individuals, such as visitors or family members, will be immediately removed from contact with the resident. The facility will ensure that no further contact with the resident in question or any other residents is possible until the investigation is completed. If necessary, law enforcement will be contacted to assist in the removal of the perpetrator/s and protection of the residents. The notification of law enforcement should be done timely and can be implemented by the charge nurse or other employee as needed. R3's (Minimum Data Set (MDS)) dated 12/9/25 documents R3 has severe cognitive impairment.R3's Care Plan dated 6/27/25 documents R3 requires assistance from staff for (Activities of Daily Living (ADLs)) specifically R3 has a self-care performance deficit due to dementia, cognitive deficits, and impaired mobility. R3's Care Plan dated 7/16/24 documents R3 has a communication problem related to social and emotional deficit. An investigation report dated 11/11/25 documents that on this day at approximately 5:06 PM, V7 (Licensed Practical Nurse (LPN)) reported to the former administrator an allegation of a verbal altercation from a visitor towards R3. This report documents that V19 (Certified Nurse Assistant (CNA)) was also a witness to this alleged incident.A progress note in R3's (Electronic Medical Record (EMR)) dated 12/12/25 at 12:13 AM documents the following: A family member of another resident observed coming down hall out to rotunda, bending down in front of resident and stating, Are you that much of a child that you have to act like this to get attention? I think you are an idiot.On 12/23/25 at 2:22 PM, V7(LPN) confirmed V7 was a witness to the incident that occurred at the facility on 11/11/25. V7 (LPN) stated she was coming down west hall headed to the dining room when she heard screaming in the rotunda and as V7 (LPN) approached that area she observed R3 sitting in his wheelchair and a visitor was in R3's face loudly screaming, why are you acting like a child, you are an idiot. On 12/23/25 at 3:35 PM, V19 (Certified Nurse Assistant (CNA)) stated R3 was sitting in the Rotunda on the afternoon of 11/11/25 when V19 overheard a visitor yelling at R3. V19 (CNA) stated the visitor was in R3's face yelling shut the F*** up, you are a Dumb A**. V19 (CNA) stated R3 looked at the visitor weird and acted like he was not sure of what was going on. On 12/23/25 at 2:50 PM, V2 (Director of Nursing) confirmed the verbal altercation involving a visitor and R3 did occur. V2 (DON) stated that an investigation was conducted, and the incident was reported to the state agency. V2 further confirmed that R3 sustained verbal abuse from the visitor.On 12/23/25 at 3:26 PM, V20 (Regional Nurse Consultant (RNC)) confirmed that the alleged event did occur on 11/11/25 and that R3 was the victim of verbal abuse. V20 (RNC) stated the Intradisciplinary Team met and put a plan into motion to prevent further verbal abuse towards R3 and other residents.

FORM CMS-2567 (02/99)
Previous Versions Obsolete

Event ID:

Facility ID:
145480

If continuation sheet
Page 2 of 2