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	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mattoon Rehab & Hcc	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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Failures at this level required more than one deficient practice statement.A. Based on observation, interview, and record review the facility failed to complete wound assessments, follow physician's orders, implement infection control during wound care for one of 15 residents (R5) reviewed for wounds in the sample list of 15. These failures resulted in deterioration of R5's wounds and infection that required hospitalization and intravenous antibiotics. B. Based on interview and record review the facility failed to develop and implement interventions for preventing skin tears for one of five residents (R6) reviewed for wounds in the sample list of 15. Findings include:A.) The facility's Skin Identification, Evaluation, and Monitoring Policy dated February 2026 documents a licensed nurse will complete weekly skin checks, wounds will be re-evaluated weekly and wound characteristics will be documented in the resident's medical record. Treatments will be administered per the health care provider's order.The Centers for Disease Control and Prevention Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) dated 7/12/22 documents: Enhanced Barrier Precautions (EBP) expands the use of PPE and refers to gown and glove use during high-contact resident care activities that provide opportunities to transfer Multidrug Resistant Organisms (MDROs) to staff's hands and clothing and indirectly transferred from resident to resident during these care activities. residents with wounds and indwelling medical devices are high risk for acquiring and colonization of MDROs. Wound care is an example of a high-contact resident care activity when gown and gloves should be worn. The facility's Hand Hygiene policy dated 2019 documents hand hygiene is the primary means of preventing the transmission of infection and staff must perform hand hygiene even when gloves are used. This policy documents the use of an alcohol based hand sanitizer is acceptable hand hygiene except when hands are visibly soiled.R5's Minimum Data Set (MDS) dated [DATE] documents R5 as cognitively intact. R5's Physician order dated 11/19/25-1/6/26 documents EBP related to wounds.R5's Wound Clinic Progress Note dated 11/26/25 documents V15 Wound Clinic Nurse Practitioner ordered daily wound care to cleanse wounds with normal saline, apply (antimicrobial fiber dressing with silver), covered with (nonadherent absorbent gel dressing), wrap with gauze roll, and apply (elastic bandage) for left lower posterior leg, right medial ankle, right posterior lower leg, left medial anterior lower leg, right anterior superior lower leg, left lateral lower leg, left medial lower leg lymphedema wounds. R5 to return in two weeks. R5's physician order dated 11/26/25-1/6/26 documents R5's wound care orders as three times weekly on Mondays, Wednesdays and Fridays during lymphedema treatments. There is no documentation in R5's chart that these changes were clarified with V15. R5's leg wound treatment orders were not transcribed to R5's November and December 2025 Treatment Administration Records (TARs). R5's Wound/Skin assessment dated [DATE] documents: Left medial calf wound measured 4.34 centimeters (cm) by 5.01 cm by 0.3 cm (length x width x depth). Right medial calf wound measured 3.4 cm by 2.73 cm by 0.2 cm. Left shin wound measured 8.01 cm by 6.87 cm by 0 cm. Right (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Actual harm Residents Affected - Few	medial malleolus measured 10.01 cm by 3.52 cm by 0.3 cm. There are no documented assessments of these wounds in R5's medical record after 12/12/26 until R5 was evaluated in the wound clinic on 1/2/26. R5's Skilled Physical Therapy Treatment Encounter Notes dated 11/21/25-12/22/25 document V12 Physical Therapy Assistant (PTA) completed wound and skin assessments and care, with no wound characteristics or specific treatments documented. On 12/20/25 V12 spoke with nursing staff regarding the deterioration of R5's wound beds with increased drainage and odor. On 12/22/25 a wound culture was obtained. R5's Nursing Note dated 12/20/2025 12:53 PM documents R5 had significant decline in leg wounds with purulent green drainage and foul odor. Physician ordered wound culture and Keflex (antibiotic) 500 milligrams three times daily for 10 days. R5's Nursing Note dated 1212/20/2025 at 4:59 PM documents unable to obtain wound culture as no culture kits were available and the local hospital laboratory was contacted to deliver more kits. Physician was notified. R5's Wound Clinic Progress Notes dated 1/2/26 document right, medial, posterior lower leg wound measured 22 cm by 19 cm by 0.2 cm and had a large amount of serosanguineous drainage. The left medial, anterior, circumferential leg wound measured 15 cm by 29 cm by 0.4 cm and had large amount of serosanguineous drainage. R5's Infectious Disease Consultation dated 1/3/26 documents R5 presented to the emergency room on 1/2/26 for worsening chronic leg wounds and concern for infection. It was reported through clinical imaging and from the wound clinic that R5 had been receiving wound care at the wound clinic and dressing changes at the nursing home, however R5's wound dressings had not been changed since 12/15/25 and had significant wound drainage. R5 had purulent drainage weeping through the dressings and foul odor. R5 was last seen in the wound clinic on 11/26/25. R5's Wound Culture dated 12/22/25 showed drug resistant organisms and R5 received intravenous antibiotics while at the hospital. R5's Hospital Discharge Instructions dated 1/8/26 document R5's discharge diagnoses included cellulitis (skin infection) to both legs, complicated wound infection, polymicrobial bacterial infection, and MDR Acinetobacter baumannii infection. R5's January 2026 TAR documents R5's leg wound treatments were not signed out as administered on four days between four days between 1/22/26 and 1/31/26. R5's Wound Clinic Progress Note dated 2/4/26 documents to follow up in two weeks. On 2/18/26 at 12:45 PM R5 stated R5 has leg wounds that should be wrapped daily, but once in a while the nurses forget to change the dressings. R5 had infection in her legs and went to the hospital. On 2/19/26 at 2:33 PM V28 Registered Nurse (RN) and V6 Wound Nurse/Licensed Practical Nurse (LPN) entered R5's room and administered R5's lower leg wound treatments. R5 was on contact precautions isolation. R5's lower legs had lymphedema (swelling) and several pink/moist wounds.On 2/19/26 at 11:43 AM V16 Certified Nursing Assistant stated about a month ago R5's legs were draining which soaked through the dressings. V28 notified an unidentified nurse who changed R5's bandages. V28 stated an agency nurse had worked the day before and had not changed R5's dressings. On 2/19/26 at 11:56 AM V15 Wound Clinic Nurse Practitioner stated V15 evaluated R5's leg wounds on 1/2/26 and the dressing were dated for three weeks prior. R5's wound care orders were for daily dressing changes. The wounds had deteriorated, had an odor and had an abundant amount of green drainage. R5 was crying due to the pain and infection, and R5 required hospitalization to treat the infection. V15 spoke with V2 Director of Nursing (DON) who confirmed R5's treatment orders were received and entered but the treatments were not completed. R5 had an appointment at the wound clinic yesterday, but the facility cancelled the appointment due to transportation issues. On 2/19/25 at 1:28 PM V11 Transportation stated V11 transports residents to appointments and was not aware that R5 had a wound clinic appointment yesterday until V11 saw a note when V11 came to work today. V11 stated V11 would have taken R5 if V11 knew about R5's appointment and the staff are to notify V11 of resident appointments. At 1:42 PM V11 stated R5's only wound clinic appointment in December was on (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	12/12/25 but R5 refused to go, so the appointment was rescheduled for 1/2/26. On 2/19/26 at 1:57 PM V10 LPN confirmed V10 entered R5's wound orders on 11/26/25 for three times weekly. V10 stated the orders were entered to be done with R5's lymphedema treatments on Mondays, Wednesdays and Fridays by V12 and the nurses were not doing R5's wound treatments. On 2/19/26 at 2:12 PM V12 PTA stated V12 was completing R5's lymphedema treatment and wound dressing changes three times weekly. V12 stated V12 did not complete wound assessments as V6 was checking R5's wounds weekly on Fridays. At 3:20 PM V12 stated R5's lymphedema therapy treatments ended 12/22/25 once R5's wounds deteriorated and started draining copious green drainage. On 2/23/26 at 2:16 PM V12 stated the facility has not done any formal wound care competencies for V12. V12 stated R5 was not on Transmission Based Precautions or EBP and V12 did not wear a gown during R5's wound treatments. V12 described the steps of R5's wound care as perform hand washing, remove outer leg wraps, apply gloves and remove wound dressings, change gloves, cleanse wounds with wound cleanser, change gloves apply clean dressings and wrap with gauze. V12 stated hand hygiene is done during the treatment only if hands are visibly soiled, otherwise just done before/after the treatment. V12 stated R5's orders were entered for three times weekly, V12 is not in the facility daily, and nursing staff should have clarified the order. On 2/19/26 at 3:09 PM V6 stated V12 was doing R5's wound treatments but then we changed that because the treatments should be done by a nurse and the nurses are responsible for assessing wounds during each treatment. V6 confirmed R5 did not have documented wound assessments after 12/12/25 until 1/2/26, besides 12/30/25 when R5 refused and no follow up attempts were documented. On 2/23/26 at 2:51 PM V2 DON stated V2 received a call from V15 Wound Clinic Nurse Practitioner reporting R5's wound dressings had not been changed. V2 confirmed there was no documentation that the treatments were administered. V2 stated ideally the treatment orders should have been on the TAR and the nurses should have taken over R5's wound care once V12 stopped. V2 stated the wound team is responsible for assessing wounds weekly. On 2/24/26 at 4:10 PM V2 stated during wound care gloves should be changed when moving from dirty to clean and hand hygiene performed with each glove change, including after removing dressings and after cleaning wounds. V2 stated an alcohol-based hand sanitizer can be used when hands are not visibly soiled. On 2/25/26 at 10:20 AM V2 stated EBP is implemented for open wounds. V2 confirmed a gown should be worn during wound care as part of EBP. B) R6's MDS dated [DATE] documents R6 has severe cognitive impairment.R6's incident report dated 1/22/26 at 1:23 PM documents R6 had skin tears found to left lower leg and shin. R6 stated she hit her leg on the bed. R6 was sitting in her wheelchair and is able to self-propel. R6's incident report dated 1/27/26 at 7:42 PM documents R6 had skin tear to left knee. R6 stated R6 bumped her knee. R6 was sitting in a wheelchair and is able to self-propel around her room. There is no documentation in R6's medical record that interventions were developed/implemented to protect skin from additional skin tears following these incidents.On 2/25/26 at 10:20 AM V2 DON confirmed there were no documented skin interventions developed and implemented after R6's skin tears.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement pressure relieving interventions for one of five residents (R1) reviewed for wounds in the sample list of 15. Findings include:The facility's Skin Identification, Evaluation, and Monitoring Policy dated February 2026 documents: Initiate preventative and/or treatment interventions as indicated and update the care plan with each intervention. Select surface based on the resident's assessment and all residents at risk for pressure ulcers are placed on a pressure-reducing surface/mattress and refers to a mattress selection algorithm. This algorithm instructs to use flip foam pressure relieving mattress for stage one and two, alternating pressure air mattress for stage three or four pressure ulcers. Schedule frequent repositioning for bed/chair bound residents. Implement interventions that increase the potential for healing and preventative measures to reduce the risk of further tissue loss. R1's Minimum Data Set, dated [DATE] documents: R1 has severe cognitive impairment, impaired range of motion of one arm and leg, requires substantial/maximal staff assistance for transfers and partial assistance for rolling in bed. R1 has two facility acquired unstageable pressure ulcers. R1's Care Plan dated as revised 1/22/26 documents R1 has impaired skin integrity related to recent surgery, impaired mobility, incontinence and Diabetes Mellitus. R1 has a stage four pressure ulcer of the left ankle and unstageable pressure ulcer of left heel. Interventions include pressure reduction boots when in bed (12/24/25) and pressure reducing mattress (10/10/25). This care plan does not include turning/repositioning needs and/or frequency. This care plan documents R1's diagnoses include Dementia, Adult T Cell Lymphoma/Leukemia not in remission, Antineoplastic Chemotherapy Induced Pancytopenia, and Type 2 Diabetes Mellitus. R1's Braden assessment dated [DATE] documents R1 as high risk for developing pressure ulcers. R1's Skin/Wound Note dated 12/24/2025 at 5:09 PM documents: New wound to left ankle, facility acquired unstageable pressure ulcer presenting as deep tissue injury. Wound measured 0.64 centimeters (cm) by 0.5 cm by 0 cm (length x width x depth) that was 100 % covered with eschar (dead tissue). R1's Skin/Wound Note dated 1/12/26 at 11:05 AM documents R1's left ankle unstageable pressure ulcer measured 1.02 cm by 1.22 cm by 0 cm, 100 % covered with slough (dead cells/fibrin). New wound to left heel, unstageable pressure ulcer measured 1.33 cm by 1.71 cm by 0 cm, 50% covered with eschar. R1's Skin/Wound Note dated 1/19/26 at 1:18 PM documents left heel wound measured 3.42 cm by 2.28 cm by 0 cm, with 50% covered with eschar. R1's left ankle stage four pressure ulcer measured 2.08 cm by 1.56 cm by 0.2 cm, 90 % slough covered. R1's Skin/Wound Note dated 1/20/2026 at 9:00 AM documents new sacral unstageable/deep tissue injury, new rear left trochanter (hip) unstageable/deep tissue injury, and new right shin unstageable/deep tissue injury all facility acquired wounds. R1's Progress Note dated 1/5/26 recorded by V27 Wound Nurse Practitioner documents: Left ankle wound differential diagnosis includes pressure injury versus diabetic foot ulcer versus arterial ulcer given the wound's dry, punched-out appearance and diabetes. V6 Wound Nurse reports footwear friction may have contributed to wound development. Per V23 (R1's Family) R1 had prior left ankle surgery with retained hardware/screws. Continue pressure relieving interventions per facility protocol including pressure reducing mattress and routine repositioning. Use offloading boots as tolerated. R1's Progress Note dated 1/19/26, recorded by V27, documents R1's left ankle wound was reclassified as a stage four pressure ulcer and was debrided (dead tissue removed) and notes R1's left heel pressure ulcer as unstageable. R1's January 2026 Treatment Administration Record (TAR) documents the order for pressure relieving boots was discontinued when R1 transferred to the emergency room and was not resumed upon return. R1's Registered Dietitian Note dated 1/14/2026 at 9:26 PM documents R1's weight was 140 pounds on 1/9/26 and has lost 32 pounds over the past month (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and has been refusing nutritional supplements. Suspect weight loss is secondary to Leukemia and overall decline. On 2/18/26 at 12:30 PM V10 Licensed Practical Nurse (LPN) stated V10 transferred R1 to the hospital (on 1/20/26) and R1 passed away while at the hospital. V10 stated R1 had deep tissue injuries to sacrum, shin and greater trochanter that weren't there the day prior and R1 wasn't eating or drinking. V10 stated R1 did not have an air mattress and was using a standard pressure relieving mattress. V10 stated R1 had dementia and used pressure relieving boots but would kick them off and remove them and was noncompliant with floating heels. V10 stated R1 required two staff assist for transfers and repositioning. On 2/19/26 at 11:43 AM V16 Certified Nursing Assistant (CNA) stated V16 looks at the CNA charting and care plan for pressure relieving interventions. On 2/23/26 at 11:17 AM V6 LPN/Wound Nurse stated pressure relieving interventions are documented on the care plan and use of pressure relieving boots are documented on the TAR. V6 confirmed R1's care plan does not include the need for repositioning/turning or the frequency or pressure relieving interventions for feet prior to 12/24/25. V6 stated the standard of care is to float heels and reposition at least every two hours. V6 stated R1's left ankle pressure ulcer was facility acquired and identified on 12/24/25 and pressure relieving boots were initiated that day. V6 stated V6 rounded with V27 on 1/19/26 and R1 did not have any new wounds at that time. V6 stated the next day V6 was notified to come and assess R1 who had three more deep tissue injuries related to pressure. V6 stated R1 was overall declining and was less active. On 2/25/26 at 11:32 AM V6 stated R1's facility acquired left ankle pressure ulcer was identified during wound rounds on 1/12/26, was unstageable and covered with eschar. The type of pressure relieving mattress depends on the location of the wound and air mattresses are used for stage three or four but leaves that up to the provider to decide. V6 stated we try to float heels or use pressure relieving boots prior to changing to an air mattress/alternating pressure mattress. V6 stated V6 did not discuss the use of this type of mattress with a provider since pressure relieving boots were in place. V6 stated V6 did not realize that the facility's standard pressure relieving mattresses are only recommended for up to stage two pressure ulcers. On 2/25/26 at 9:10 AM V2 Director of Nursing confirmed R1's pressure relieving boots were not resumed on R1's TAR after 1/8/26 and should have been. The undated manufacturer's information for the facility's flip foam pressure relieving mattress, provided by V1 Administrator, documents this mattress may be appropriate for up to stage two pressure wounds but should be based on a resident specific assessment.

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F 0689 Level of Harm - Minimal harm or potential for 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 interview and record review the facility failed to prevent falls by failing to identify trip hazards and implement fall interventions and failed to thoroughly investigate falls for two of three residents (R4, R14) reviewed for falls in the sample list of 15.Findings include:The facility's Skilled Fall Policy dated May 2025 documents: Residents will be provided care and services to ensure their environment is as free from accident hazards as possible. An occurrence report will be completed after each fall to determine root cause and interventions will be implemented.1.) R4's Minimum Data Set (MDS) dated [DATE] documents R4 has severe cognitive impairment and requires partial/moderate staff assistance for transfers and toileting.R4's active care plan documents R4 is at risk for falls related to muscle weakness, dementia, impaired hearing and vision, impaired balance, and history of falls. Interventions include call don't fall sign (12/14/23), assist to bathroom as needed (2/10/25), call don't fall sign in bathroom (1/25/24), nonskid grip strips in front of bathroom door (8/21/25), nonskid grip strips in front of recliner (12/10/24), nonskid grip strips on bathroom floor (12/14/23), and nonskid grip strips replaced in front of toilet due to being worn out (1/10/26).R4's Fall Report dated 1/10/26 at 10:55 AM documents R4 was yelling for help and staff found R4 lying on right side in front of the toilet. R4's pants were down to midthigh and R4 was incontinent of bowel movement. R4 reported R4 was trying to go to the bathroom. R4 had a hematoma (swelling) to her forehead. V40 MDS Coordinator noted the grip strips in front of R4's toilet were worn down and V40 replaced the strips. This investigation does not identify when R4 was last toileted prior to this fall.R4's Fall Report dated 1/19/26 at 12:15 AM documents R4 was found on the floor of R4's room and reported pain to right wrist and right forearm from prior fall and left hip pain. V46 Certified Nursing Assistant (CNA) statement documents V46 heard R4 yelling for help and found R4 on the floor in front of her bathroom. The interdisciplinary team note documents R4 attempted to get up unassisted and fell, R4 was more confused due to recent room change. There is no documentation that R4's new room had call don't fall signs and grip strips in place at the time of R4's fall.On 2/24/26 at 11:43 AM V47 (R4's Family) stated V47 visited on 1/14/26 and R4's arm was swollen and face was bruised due to a fall. V47 stated R4 had another fall after a room change, R4's call don't fall signs and nonskid strips were not moved with R4 that day. V47 stated R4 self-transfers to get to the bathroom if staff don't offer to take R4.On 2/24/26 at 10:39 AM in regard to R4's 1/10/26 fall, V40 stated: V40 had walked by R4's room and found R4 lying on the floor, R4 had attempted to self-transfer to the bathroom. R4 had a goose egg hematoma to her forehead. V40 noticed the grip strips on the floor were worn down and V40 questions if that was the cause of R40's fall.On 2/24/26 at 11:02 AM in regard to R4's fall on 1/19/26, V42 Registered Nurse stated R4 normally is good about using her call light but that night R4 was in a new room and did not call. V42 stated R4 wasn't herself and was more confused that night. V42 stated R4 was in the recliner prior to the fall and attempted to self-transfer, there were no grip strips on the floor or call don't fall signs on R4's wall.On 2/24/26 at 4:10 PM V2 Director of Nursing (DON) stated V2 took over fall investigations in January. V2 confirmed all fall investigation documentation was provided for R4's falls. V2 stated the grip strips were found to be worn as the root cause of R4's 1/10/26 fall. V2 stated ideally the nursing staff should be checking the grip strips each time they are providing cares. V2 confirmed the 1/10/26 fall investigation does not document the last time R4 was toileted. V2 stated grip strips and call don't fall signs were current interventions and should have been moved with R4 to her new room. V2 stated the nursing staff are responsible for moving the grip strips and call don't fall signs during room changes. V2 confirmed the fall (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigation does not document if these interventions were in place when R4 fell on 1/19/26. 2.) R14's MDS dated [DATE] documents R14 has severe cognitive impairment and requires partial/moderate staff assistance for chair/bed/toilet transfers.R14's Fall Report dated 12/19/25 at 8:58 AM documents R14 was found sitting on his buttocks on the floor beside R14's bed. This fall investigation contains staff interview statements but does not identify the last time R14 was toileted prior to this fall. The interdisciplinary note dated 12/24/25 documents R14 attempted to self-transfer from wheelchair to bed and fell onto the floor, and R14 was incontinent at the time of the fall. R14 was unable to say what happened. New intervention was nonskid grip strips next to bed. R14's Fall Report dated 2/3/26 at 4:57 AM documents V36 Licensed Practical Nurse (LPN) responded to R14 yelling for help. R14 was lying on the floor on his left side with wheelchair foot pedal underneath R14, and wheelchair was tipped up behind R14. R14 had a skin tear to left chest. This fall investigation contains staff interviews but does not identify if R14 had a nonskid mat in R14's wheelchair. The interdisciplinary note documents R14 was in the hallway and attempted to move his wheelchair forward, R14 fell out of the wheelchair and landed on the floor. R14's care plan was updated to replace the nonskid mat in the wheelchair. R14's Nursing Note dated 2/19/2026 at 2:25 PM documents nurse called to R14's room and R14 was sitting on the floor mat on the floor next to R14's bed. CNA (V38) was transferring R14 from wheelchair to bed, V38's foot got caught on floor mat, V38 was unable to regain balance and sat R14 on the floor. R14 bumped right elbow on wheelchair and received a crescent shaped skin tear. On 2/24/26 at 10:18 AM V41 CNA stated V41 had just gotten R14 up a few minutes prior to the fall on 12/19/25 and V41 could not recall if a nonskid mat was in R14's wheelchair when R14 fell. On 2/24/26 at 1:07 PM V38 CNA stated last week V38 transferred R14 with gait belt to bed. V38 stated V38 did not pick up the floor mat, V38's foot caught on the mat causing V38 to lose her balance and V38 lowered R14 to the floor. V38 stated R14 bumped his arm on the wheelchair causing a skin tear to right elbow. V38 stated V38 should have picked up the floor mat to prevent the fall. On 2/24/26 at 4:10 PM V2 DON confirmed all documentation was provided for R14's fall investigations. V2 stated R14 fell on 2/3/26 and the nonskid mat was replaced, V2 could not recall if it was because the nonskid mat wasn't in place or if it was because it was worn. V2 confirmed this information is not documented in R14's fall investigation. V2 stated this past Thursday R14 fell during staff assisted transfer and post fall intervention was to pick up the fall mat when R14 is out of bed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review the facility failed to accurately account for and destroy controlled medications for three of four residents (R7, R9, R15) reviewed for controlled medications in the sample list of 15. Findings include: The facility's Controlled Substance Destruction Policy dated December 2024 documents: Controlled substances should be destroyed with a licensed nurse and licensed professional. The destruction, quantity destroyed, and date should be documented on the controlled medication count sheet and signed by the nurse and the witnessing licensed professional.The facility's Controlled Substance Policy dated December 2024 documents the nurse will sign the controlled medication out on the Controlled Substance Proof of Use Form immediately and document the medication on the Medication Administration Record (MAR) immediately after administration.1.) R9's Controlled Substance Record for Diazepam 2 milligrams (mg) documents single doses were dispensed on 1/25/26, 1/30/26, 2/2/26 and 2/8/26 between 10:30 PM and 12:30 AM, signed by V31 Licensed Practical Nurse (LPN). These entries are not recorded on R9's January and February 2026 MARs as there is no active order entered after 1/22/26. R9's Census documents R9 discharged from the facility on 2/14/26.On 2/18/26 at 10:16 AM the controlled medications in the medication cart on the Lotus Hall were checked with V10 LPN. R9's Diazepam cards contained six remaining tablets and a full card of 14 tablets. V10 stated R9 discharged to assisted living and these medications should be destroyed with the Director of Nursing (DON) or Assistant DON (ADON), but they haven't gotten to it yet. On 2/23/26 at 2:51 PM V2 DON stated when controlled medications are discontinued or the resident expires the nurse should bring the card to the ADON or DON as soon as possible to be destroyed. On 2/25/26 at 10:20 AM V2 stated R9 had an active order for Diazepam that the pharmacy sent a script for on 1/30/26, the order just wasn't placed into R9's electronic medical record and MAR. V2 confirmed the controlled medication entries on the count sheet should match the MAR. On 2/25/26 at 10:39 AM V31 stated R9 always called for Diazepam after 9:00 PM and V31 must have given the medication out of habit without checking to verify it was on the MAR. V31 stated that is my mistake, I should have checked the MAR. 2.) R7's Controlled Substance Record for Lorazepam 0.5 mg documents on 2/9/26 the remaining 13 tablets were destroyed by V10 LPN. R7's Controlled Substance Record for Norco 5/325 mg documents on 2/9/26 the remaining 9 tablets were destroyed by V10. The Narcotics Destruction Form dated 2/9/26 documents V10 destroyed R7's Lorazepam and Norco tablets and R15's Norco 5/325 mg 60 tablets, 15.5 milliliters (ml) of Morphine Sulfate 100 mg/5 milliliters (ml), 20 ml of Lorazepam concentrate 2 mg/ml, and 10 Fentanyl 25 microgram/hour patches. These forms are not signed by a second person who witnessed the destruction of these medications.On 2/23/26 at 2:51 PM V2 DON stated controlled medications are destroyed with a floor nurse and either the DON or ADON, with two signatures documented on the destruction form. On 2/25/26 at 9:20 AM V10 reviewed the controlled medication forms dated 2/9/26 and confirmed V10 is the only signature listed for the destruction of R7's and R15's listed medications. V10 stated V10 destroyed the medications with V3 ADON but V3 must have forgot to sign the form. On 2/25/26 at 9:48 AM V3 stated V3 destroyed the controlled medications on 2/9/26 with V10, but V3 forgot to sign the destruction forms.

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	145480	A. Building B. Wing	02/25/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an effective infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This failure affects 4 of 6 residents (R1, R11, R12, R13) reviewed for infection control practices. 1.) The Centers for Disease Control and Prevention (CDC) Transmission Based Precautions dated 4/3/24 documents for contact precautions wear gown and gloves for all interactions that may involve contact with the patient or patient's environment, apply Personal Protective Equipment (PPE) upon room entry, and discard PPE before exiting the room.The facility's undated Respiratory Syncytial Virus (RSV) policy documents: RSV is transmitted through droplets when the infected person coughs or sneezes and droplets can enter the eyes, nose or mouth. RSV can be transmitted with direct contact with the virus or through contact with an infected surface as RSV can survive for hours on hard surfaces. R12's Physician's Order dated 2/13/26 documents Maintain Droplet Isolation for Coronavirus & RSV. These orders do not include Contact Precautions.R13's Physician's Order dated 2/17/26 documents Droplet Precautions for active RSV.On 2/18/26 at 10:27 AM R12's and R13's room doors had droplet isolation signs posted indicating to apply a mask and cover eyes, and the room doors contained PPE containers. R13's PPE container did not contain gowns. There were no contact isolation signage posted for R12's or R13's rooms. On 2/18/26 at 12:15 PM R12 stated R12 admitted from the hospital with a respiratory infection and has a cough. R12 stated staff only wear masks when in R12's room. On 2/18/26 at 12:20 PM V21 Certified Nursing Assistant (CNA) was in R13's room, not wearing a gown while assisting R13 into the bathroom. At 12:25 PM V22 CNA applied PPE to enter R13's room and V21 told V22 that V22 did not need to wear a gown since R13 was not on contact precautions, only droplet precautions. V22 stated both R12 and R13 are on droplet precautions for RSV. At 12:40 PM V21 stated R12 and R13 are on droplet precautions, and only mask and gloves are required in their rooms. On 2/19/2026 at 9:00am R12's door contained Droplet Precaution signage and there were two masks hanging on the sign obstructing the full view of the isolation sign. The PPE container on the door contained gloves, gowns, and masks. On 2/19/2026 at 9:01am R13 was in his recliner with mask on and coughing. Two masks were hanging on R13's door obstructing the view of the Droplet Precautions sign. Gloves, masks and gowns were in the PPE container on the door. On 2/19/2026 at 10:25 AM V4 Occupational Therapist (OT) assisted R13 with walking in R13's room and a mask was the only PPE V4 was wearing. On 2/24/26 at 12:40 PM The sign on R13's door indicated contact and droplet precautions and to wear gown, gloves, mask, and eye protection. V43 CNA delivered R13's meal tray into R13's room while wearing only a mask. V43 touched R13's overbed table and was within close proximity to R13. V43 collected a used disposable cup from R13's overbed table and V43 was not wearing gloves. V43 left R13's room carrying the cup into the hallway and V43 had not discarded her mask upon leaving R13's room. V43 confirmed V43 did not wear gown, gloves, and eye protection in R13's room while coming into contact with R13's overbed table and touching the used disposable cup. V43 confirmed V43 did not discard her mask upon leaving R13's room. V43 stated R13 has RSV but V43 did not think gown, gloves and eye protection were required to deliver R13's meal tray. On 2/19/2026 at 10:32 AM V4 OT stated R13 was on droplet precautions, and it is required in this facility to wear a gown, gloves, and a mask when providing care to a resident that is on droplet precautions. V4 stated V4 did not wear a gown and V4 had removed V4's gloves without applying new gloves while continuing to provide R13's care. On 2/19/2026 at 2:55 PM V1 stated the facility would follow CDC guidelines regarding droplet precautions. On 2/19/2026 at 3:30 PM V5 Licensed Practical Nurse (LPN) stated it is (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and did not perform hand hygiene after cleansing R11's wound prior to applying the clean dressing. On 2/19/26 at 3:31 PM V17 confirmed V17 and V18 LPN did not wear gowns during R11's wound care. V17 stated V17 changed gloves during R11's wound care but did not perform hand hygiene because V17 thought that was only needed when hands are visibly soiled, and not necessary with each glove change. On 2/24/26 at 4:10 PM V2 DON stated during wound care gloves should be changed when moving from dirty to clean and hand hygiene with each glove change, including after removing the dressing and after cleaning the wound because hands would be considered dirty, prior to applying clean dressing. V2 stated alcohol-based hand sanitizer can be used when hands are not visibly soiled otherwise handwashing is needed.