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	04/24/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free from verbal abuse by employees. This failure affected three of five (R2, R4, and R6) residents reviewed for abuse in a sample of six residents. Findings:The facility's Abuse, Prevention and Prohibition Policy dated November 2025 documented that each resident has the right to be free from 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, volunteers, staff of other agencies, family members or legal guardians, friends, or other individuals.The policy prohibits mistreatment, neglect, and abuse, including the deprivation of goods or services necessary to attain or maintain a resident's physical, mental, and psychosocial well-being. It identifies prevention as a key component and affirms the resident's right to be free from verbal, mental, sexual, exploitative, or physical abuse, as well as corporal punishment and involuntary seclusion. The policy documented that the facility will regularly reassess care plan interventions and implement strategies based on resident screenings to prevent occurrences of abuse.On 04/24/2026 at 8:53 a.m., R2 was observed lying in bed covered with a blanket and reported that an evening/night shift CNA (R2 can't recall name) consistently tells her to pull up your own incontinence brief. R2 stated this CNA speaks to her in a mean and disrespectful manner, and it causes her emotional distress. R2 stated, I don't like it, and stated this CNA always speaks to her that way.R2's Minimum Data Set (MDS) dated [DATE] documented that R2 has moderate cognitive impairment. This MDS documented that R2 requires substantial/maximal assistance from staff for toileting hygiene tasks.R2's Electronic Health Record (EHR) contains a progress note dated 4/10/26 that documented V1, Administrator was notified of R2's report that a Certified Nursing Assistant (CNA) spoke to her in a verbally abusive manner and did not provide care to meet her needs. The allegation was reported to administration, and an investigation was initiated. A head-to-toe skin assessment was completed, and R2's physician and Power of Attorney/emergency contact were notified. The (local) Police Department and the Ombudsman were also informed of the allegations of verbal abuse.On 4/24/26 at 10:06 a.m., V11, CNA, reported that R2 stated a night shift CNA was consistently rude and disrespectful. V11 stated R2 also reported this concern to V14, an agency CNA. According to V11, R2 was unable to recall the alleged perpetrator's name but provided a description. V11 further stated R2 reported that the CNA instructed her to perform toileting tasks independently, telling her she could do it herself in a mean and condescending tone.On 04/24/2026 at 10:53 a.m., V14, CNA, stated R2 told V14 that a night shift CNA identified as V8 consistently tells R2 to perform tasks independently, including transfers, toileting, and toileting hygiene. V14 stated R2 has appeared down and sad recently and reported to V14 that her interactions with V8 have been upsetting to her because of how rudely V8 speaks to R2 . V14 further stated R2 expressed hesitation to call for assistance when V8 is working due to fear of upsetting V8.A state report dated 4/10/26 documented that R2 reported that a CNA spoke to her in a verbally abusive manner and did not provide care to meet her needs. The allegation was reported to administration, and an investigation was initiated. MD and POA/emergency contact were made aware.On 4/24/26 at 12:12 p.m., R4 stated that (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

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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	a few staff members have spoken to him in a condescending or disrespectful manner. R4 further reported that, during a recent night shift, staff left him in a soiled incontinence brief after informing him they would return to provide care but did not come back to assist him. R4 did not describe physical harm or direct abuse; however, he expressed concern regarding the tone and manner in which staff spoke to him during that incident.R4's MDS dated [DATE] documented that R4 is cognitively intact.On 4/24/26 at 12:28 p.m., R6 stated that some nurses and CNAs at the facility have spoke to him in a rude and disrespectful manner (names not recalled). R6 stated he previously brought this concern to management and stated that V4, Social Services Director (SSD), followed up with him regarding his concerns and told R6 she would look into the situation.R6's MDS dated [DATE] documented that R6 is cognitively intact.On 04/24/2026 at 2:52 p.m., V4, SSD, stated that R6 recently brought concerns to her attention regarding staff attitudes, specifically reports of rudeness and disrespect. V4 stated she could not recall the specific details at the time but indicated she would provide documentation showing the matter had been investigated.On 04/24/2026 at 1:53 p.m., V3, Assistant Director of Nursing (ADON) stated that the expectations of facility staff is that verbal abuse, disrespect, and rudeness are not acceptable. She reported she was aware of the concerns involving R2 and stated the Administrator (V1), who serves as the abuse coordinator, handled the situation. V3 reported that the alleged staff member was removed from the schedule, and an investigation was conducted. V3 emphasized that the expectation is for residents to feel comfortable requesting assistance without fear of upsetting staff and that such concerns are taken seriously.