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	05/19/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to ensure resident shower rooms were maintained in a safe, clean manner and in good repair for two of three shower rooms located on [NAME] Hall and [NAME] Hall. This failure has the potential to affect 64 of 64 residents (R4 and R7 through R69) reviewed for homelike environment in the sample list of 69.Findings include:Observations were conducted on May 15, 2026 between 3:00PM and 3:15 PM on [NAME] Hall and [NAME] Hall.Beacon Hall Shower Room: Sections of floor tile were missing, leaving uneven and damaged areas. Portions of wallboard were missing, exposing underlying material. Debris was present on the floor, and the room appeared visibly dirty. A black substance was noted along the shower walls and in the floor corners.West Hall Shower Room: Multiple tiles were missing from the shower floor. Shower chairs, a shower bed, and a mechanical lift were blocking the toilet so the toilet was not accessible. Dirt and debris were present on the floor. A black substance was present along the wallˆtoˆfloor junctions and shower corners.During interviews on May 15, 2026 at 3:30 PM V1, Administrator, stated the shower rooms were in need of repair and confirmed that these conditions had been present for some time. On 5/15/26 at 3:45 PM R4 and R5 stated, Yes that shower room needs lots of work, especially under the sink there is no wall. On 5/19/26 at 2:10 PM V1 Administrator stated there were no work orders in place to have the rooms repaired. The Midnight Census Report dated 5/19/26 at 3:03 pm documents R4 and R7-R69 use the [NAME] Hall and/or [NAME] Hall shower rooms.

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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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to follow physician orders for insulin administration for one (R3) of three residents reviewed for quality of care in a sample of 69. This failure resulted in R3 receiving a dose of insulin via a syringe while simultaneously receiving insulin from an insulin pump, causing hypoglycemia, decline in condition, and hospitalization. This past noncompliance occurred from 4/2/2026 to 4/6/2026.Findings include: R3's Census, within the facility's Electronic Health Record, documents an initial admission date to the facility as 3/18/2026.R3's undated Care Plan documents a readmission date to the facility as 4/6/2026 with the following diagnoses: Acute Kidney Failure, Hyperkalemia, Chronic Kidney Disease, Stage 3, Muscle Weakness, Need For Assistance With Personal Care, Hypo-Osmolality And Hyponatremia, Hypertensive Heart Disease Without Heart Failure, Type 2 Diabetes Mellitus With Hyperglycemia, Long Term Use of Insulin, Unspecified Cirrhosis Of Liver, Thrombocytopenia, Hypothyroidism, Morbid (Severe) Obesity Due To Excess Calories, Obstructive Sleep Apnea, Hyperlipidemia, Old Myocardial Infarction, Gastro-Esophageal Reflux Disease Without Esophagitis, Squamous Cell Carcinoma Of Skin, Personal History of other Venous Thrombosis and Embolism, and Hepatic Encephalopathy.R3's Physician Order dated 3/19/26 documents Insulin Aspart Solution 100 milligram per milliliter, Inject 140 units subcutaneously one time a day for Diabetes Mellitus II unsupervised self-administration via insulin pump; change every three days.R3's Medicine Administration Record for 4/2/2026 indicates R3's order for Insulin Aspart was marked as administered at 8:00 AM. No documentation was available for review indicating the dose given.R3's Blood Sugar Summary for 4/2/2026 contains blood sugar results as follows:4/2/2026 at 7:31 AM - 169.0 milligrams per deciliter4/2/2026 at 11:35 AM - 50.0 milligrams per deciliter4/2/2026 at 11:36 AM - 78.0 milligrams per deciliter4/2/2026 at 4:06 PM - 81.0 milligrams per deciliterThe Center for Disease Control lists a normal blood sugar range to be within 80-130 milligrams per deciliter and blood sugar readings below 70 milligrams per deciliter are considered hypoglycemic.R3' Medication Administration Record for 4/2/2026 documents Glucose gel was administered to R3 by V8 Licensed Practical Nurse at 11:35 AM.The Emergency Department Report dated 4/6/2026 documents R3 was admitted to the hospital medical floor on 4/3/2026 at 3:35 PM for observation with admitting diagnoses of Acute Altered Mental Status and Suspected Hepatic Encephalopathy. The Report documents R3 presented from a rehabilitation facility via EMS (Emergency Medical Services) for altered mental status and decreased responsiveness. Per report, she had been less responsive since the prior morning, with concern raised for possible excess insulin administration in the setting of an insulin pump.On 5/13/2026 at 12:53 PM, V7 (R3's family member) stated he arrived at the facility on 4/2/2026 at approximately 11:30 AM and observed R3 to be lethargic and confused. V7 stated R3 informed him the nurse on duty had administered insulin prior to his arrival via a syringe while R3 was wearing an active insulin pump. V7 stated V8 (Licensed Practical Nurse) initially denied administering insulin and later admitted to administering insulin to R3 via syringe. V7 stated staff provided R3 orange juice throughout the evening due to declining condition. V7 stated when he returned to the facility the following day, R3 was nearly unresponsive, and he demanded staff contact emergency medical services. V7 stated R3 was subsequently hospitalized .On 5/13/2026 at 4:43 PM, V8 (Licensed Practical Nurse) stated she administered insulin to R3 via syringe on 4/2/2026 while R3 was wearing an active insulin pump during the facility's morning medication administration. V8 LPN stated she could not recall the dose or the exact time the insulin was given. V8 stated the medication error occurred due to V8 LPN misinterpreting the physicians order for insulin.On 5/14/2026 at 12:10 PM, V11 Physical Therapist Assistant stated R3's insulin pump alarmed for low blood glucose around noon on 4/2/2026. V11 stated she informed nursing staff and overheard V8 Licensed Practical Nurse acknowledge administering insulin to R3 because R3 reportedly stated the insulin pump did not administer insulin. V11 stated R3 appeared very lethargic at that time and required orange juice with sugar for intervention.On 5/13/2026 at 11:16 AM, (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	V5 Registered Nurse stated R3 utilized an insulin pump with a wearable blood glucose monitoring device and did not receive insulin via syringe administration.On 5/13/2026 at 8:10 AM, V2 Director of Nursing stated she became aware of the medication error on 4/3/2026 after R3 was observed lethargic and difficult to arouse. V2 stated the Medical Director was notified and R3 was transferred to the emergency room for evaluation. On 5/14/2026 at 3:25 PM, V3 (Assistant Director of Nursing) stated the insulin administered to R3 on 4/2/2026 via syringe occurred due to V8 Licensed Practical Nurse misinterpreting the physicians order for insulin and considered V8's mistake as a significant medication error.On 5/18/2026 at 11:45 AM, V14 (Medical Director) stated the incorrect dose of insulin administered to R3 by V8 on 4/2/2026 contributed to R3's hospitalization on 4/3/2026.Prior to the survey date, the facility took the following actions to correct the noncompliance. On 4/3/2026 V1 Administrator educated V2 Director of Nursing and V3 Assistant Director of Nursing on the topic of safe medication administration, correct order processing, and assessing and notifying when medication errors occur.On 4/3/2026 registered and licensed staff were in-serviced by V2 Director of Nursing on the following topics:Medication Administration policy regarding interpreting physician orders, entering physician orders and medication administration.Residents should be assessed, and the physician should be notified in the event a medication error occurs. 3. On 4/6/2026 Audits were conducted by V2 Director of Nursing to ensure compliance with physician order interpretation, transcription and medication administration for residents receiving insulin. 4. On 4/3/2026 V2 Director of Nursing conducted an audit of the last 30 days of new admission and readmission resident's prescribed insulin to ensure physician orders were entered accurately and their medication was administered per physician order. 5. On 4/6/2026 residents receiving insulin were reviewed and audited by V2 Director of Nursing to ensure physician orders were entered accurately and their medication was administered per physician order.