

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145890	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER Eldorado Rehab & Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 A Jefferson Street Eldorado, IL 62930	
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 - Few Note: The nursing home is disputing this citation.	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** Based on interview, and record review, the facility failed to ensure staff treated a resident with dignity and respect by not interacting in a manner that enhanced self-worth and quality of life for 1 (R1) of 4 residents reviewed for Resident Rights in the sample of 4. Findings Include: R1's, admission Record, documented R1 admitted to the facility on [DATE]. R1's diagnoses listed include cerebral ischemia, other speech and language deficits following cerebral infarction, cognitive communication deficit, aphasia, dysphonia, Parkinsonism, weakness, and transient cerebral ischemic attack. R1's Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) of 14, indicating R1 is cognitively intact. R1's document titled, Summary of Daily Skilled Service, dated 04/03/2026, documented implemented functional transfer training with V3 (Family Member) using V3's vehicle. R1 required max assist with sit to stand transfers, stand pivot transfers, and was dependent with sitting on the very edge of seat in the car. R1 would fall back into a severe posterior lean and would not attempt to move herself in any direction and would not assist with transfer. V8 (Physical Therapy Assistant) provided max assist to hold patient in upright posture. R1 relied on V8 to place R1's lower extremities into the vehicle. R1 was slouched downward in the seat and received max encouragement and prompts. R1 refused to participate two times with V8 and one time with V3. R1 continued to rely on the physical assistance and demonstrated that she is not able to perform a car transfer safely. V8 recommended to V3 that family travel with R1 in a lower vehicle to prevent fall risk. R1 was not cooperative or motivated to participate in car transfers despite encouragement from V8 and V3. It was discussed with V3 and R1 that R1 has reached her plateau in progress with physical therapy services at this time due to noncompliance with exercising and increasing activity during the day as R1 sits in the recliner all day. On 07/07/2026 at 3:31 PM, V3 (Family Member) stated the incident occurred on 04/03/2026 and R1 was working with V8. V3 stated V8 sat down on the bed and was discussing that V8 thought R1 would have gotten more movement back after her stroke. V3 stated V8 asked R1 if she was doing the exercises she was given to be done when not in therapy. V3 stated V8 asked R1 what she did when she was not in therapy. V3 stated V8 was raising her voice to R1. V3 stated V8 said to R1, Look at me, I am talking to you. V3 stated throughout the interaction she was patting R1 on the back. V3 stated V8 was eye level with R1 and was talking to her. V3 stated that V8 had a nosebleed because she was so upset. V3 stated V8 asked R1, Do you remember me giving you therapy? and R1 replied, No. V3 stated this upset V8, and V8 loudly said, I am not going to be accused of Medicaid fraud. V3 stated V8 continued to be loud saying, You can't tell people that I am not here when I am here. V3 stated you could tell this upset V8 a lot. V3 stated V8 then raised her voice and yelled, You could get me fired for saying that. V3 stated she tried to calm V8 down. V3 stated R1 did not realize when she was receiving therapy from someone other than V8, that she was (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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to report an allegation of staff to resident verbal abuse timely to the State Survey Agency and local law enforcement for 1 (R1) of 4 residents reviewed for abuse in the sample of 4. Findings include: R1's, admission Record, documented that R1 admitted to the facility on [DATE]. R1's diagnoses include cerebral ischemia, other speech and language deficits following cerebral infarction, cognitive communication deficit, aphasia, dysphonia, Parkinsonism, weakness, and transient cerebral ischemic attack. R1's Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) of 14, indicating that R1 is cognitively intact. On 07/07/2026 at 9:27 AM, V1 (Administrator) stated she was made aware, around lunch time on 04/03/2026, that V8 was in R1's room and was talking very loudly. V1 stated she immediately went to R1's room and V3 (Family Member) had already left. V1 stated she spoke to R1 and R1 was only concerned about not receiving therapy. V1 stated she went back to her office and called V3 on the phone. V1 stated during the conversation with V3, V3 never once said anything about abuse. V1 stated the conversation that she had with V3 did not lead her to believe V3 was making an abuse accusation. V1 stated if she had been told an abuse allegation, she would have handled the situation differently. V1 stated V3 never told her that V8 was loud, threatening, or abusive. V1 stated V3 just kept saying it was just a miscommunication. On 07/07/2026 at 1:05 PM, V4 (Chief Operating Officer) stated the facility has no verbal abuse allegations that have been reported. The initial report was received at the State Survey Agency on 07/07/2026 at 3:54 PM via email. It documented: An allegation of verbal abuse was reported by a State Agency Surveyor. Surveyor reports an allegation against V8 (Physical Therapy Assistant). Surveyor states that the allegation is that V8 raised her voice, got in R1's face and said, don't turn your head when I'm talking to you, and made accusation of Medicaid fraud. R1 was discharged home on May 31, 2026. V8 has been suspended pending investigation. Attending Physician, Power of Attorney, Local Police and Ombudsman have been notified. Final report within 5 days. The final report was reported to the State Survey Agency on 07/08/2026 at 4:59 PM via email, documenting: Interviewable residents were interviewed, including those that are on therapy case load, with no one reporting that V8 had mistreated or spoken inappropriately to them. Facility staff were interviewed with no one reporting that they have witnessed V8 being abusive in any way. This issue was previously reviewed, and V8 was disciplined according to facility policy for unprofessionalism on 4/6/2026. After a thorough investigation we do not substantiate verbal abuse with this incident. Attending Physician, POA, and Ombudsman will be notified of the investigation findings. On 07/09/2026 at 9:05 AM, V9 (Director of Therapy) stated at no point in the conversation with V3 did V3 ever mention any words that would have made me think it was abuse. V9 stated V3 just kept saying it was a miscommunication and that she thought V8 was a blessing to R1. V9 stated V3 said it was water under the bridge and wanted V8 to continue seeing R1. V9 stated if V3 thought it was abuse, why would she want V8 to continue seeing R1. On 07/09/2026 at 9:17 AM, V1 stated after the conversation she had with V3, she did not feel that V8 had abused R1. V1 stated while she was on the phone with V3, V3 kept repeating that it was all a misunderstanding from her mom not understanding that V8 was there every day to provide therapy. The facility Policy titled, Abuse Prevention, dated 08-16-2025, documented: VII. External Reporting of Potential Crime and Abuse1. Reporting of allegations. Upon report of any allegation of a crime, suspicion of a crime, potential abuse, neglect, mistreatment or exploitation, the administrator is required to notify the Illinois Department of Public Health, the local police, and the ombudsman immediately or within 1 hour of the alleged violation.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to thoroughly investigate an allegation of staff to resident verbal abuse for 1 (R1) of 4 residents reviewed for abuse in the sample of 4. Findings include: R1's, admission Record, documented that R1 admitted to the facility on [DATE]. R1's diagnoses include cerebral ischemia, other speech and language deficits following cerebral infarction, cognitive communication deficit, aphasia, dysphonia, Parkinsonism, weakness, and transient cerebral ischemic attack. R1's Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) of 14, indicating that R1 is cognitively intact. The initial report was received at the State Survey Agency on 07/07/2026 at 3:54 PM, via email. It documented: An allegation of verbal abuse was reported by a State Agency Surveyor. Surveyor reports an allegation against V8 (Physical Therapy Assistant). Surveyor states that the allegation is that V8 raised her voice, got in R1's face and said, don't turn your head when I'm talking to you, and made accusation of Medicaid fraud. R1 was discharged home on May 31, 2026. V8 has been suspended pending investigation. Attending Physician, Power of Attorney, Local Police and Ombudsman have been notified. Final report within 5 days. The final report was reported to the State Survey Agency on 07/08/2026 at 4:59 PM, via email, documenting: Interviewable residents were interviewed, including those that are on therapy case load, with no one reporting that V8 had mistreated or spoken inappropriately to them. Facility staff were interviewed with no one reporting that they have witnessed V8 being abusive in any way. This issue was previously reviewed, and V8 was disciplined according to facility policy for unprofessionalism on 4/6/2026. After a thorough investigation we do not substantiate verbal abuse with this incident. Attending Physician, POA, and Ombudsman will be notified of the investigation findings. R1's electronic medical record was reviewed and there was no documentation of the incident. On 07/07/2026 at 2:11 PM, V5 (Business Office Manager) stated she was walking from the administrator's office back towards hers when she heard V8 (Physical Therapy Assistant) saying to R1 in a loud tone, You're going to get me in trouble for Medicaid fraud. V5 stated she went and got V9 (Therapy Director). V5 stated herself and V9 went to tell V1 (Administrator). On 07/07/2026 at 3:04 PM, V9 (Therapy Director) stated she did not hear V8 yell at R1. V9 stated V3 was talking about it in the hallway. V9 stated she asked V3 about the alleged incident. V9 stated she went to V1 (Administrator) and discussed the situation with her. V9 stated V3 had already left the building so V1 and herself called V3 on the phone V9 stated at no time during the conversation did V3 allege any allegations of abuse. On 07/07/2026 at 9:27 AM, V1 (Administrator) stated she was made aware, around lunch time on 04/03/2026, that V8 was in R1's room and was talking very loudly. V1 stated she immediately went to R1's room and V3 had already left. V1 stated she spoke to R1 and R1 was only concerned about not receiving therapy. V1 stated she went back to her office and called V3 on the phone. V1 stated during the conversation with V3, V3 never once said anything about abuse. V1 stated the conversation that she had with V3 did not lead her to believe V3 was making an abuse accusation. V1 stated if she had been told an abuse allegation, she would have handled the situation differently. V1 stated V3 never told her that V8 was loud, threatening, or abusive. V1 stated V3 just kept saying it was just a miscommunication. On 07/09/2026 at 9:17 AM, V1 stated after the conversation she had with V3, she did not feel that V8 had abused R1. V1 stated she investigated the incident as soon as V5 and V9 brought it to her attention. V1 stated she immediately went to R1's room and V3 was already gone. V1 stated she and V9 called V3 on the phone at 1:39 PM. V1 stated this phone call lasted roughly 18 minutes. V1 stated she did not see it as abuse. V1 stated if at any (continued on next page)		

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