STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145584	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Mattoon	1000 Palm 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** 31642 Based on record review and interview the facility failed to protect a resident's right to be free from physical abuse by another resident. This failure affects one of four residents (R2) reviewed for abuse on the sample list of 14. Findings include: R1's Current Diagnoses Sheet includes the following: Schizophrenia, Unspecified, and Major Depressive Disorder Recurrent. R1's Brief Interview of Mental Status Evaluation dated 11/13/24 documents R1's score as five out of a possible 15, indicating severe cognitive impairment. R1's Care Plan dated 11/08/24 documents the following: Focus: Behavior: Verbal/physical: Resident has behaviors that others may find disruptive/socially inappropriate. Others may seek reprisal against this Resident. Behavior exhibited Verbal aggression. Physical aggression. The same Care plan documents Intervention: Intervene as needed as soon as behavior is noted to ensure safety of residents and others. R1's Health Status Note dated 12/15/24 at 9:06 am documents the following: Resident (R1) smacked another resident (R2) this morning. R2's Current Diagnoses Sheet includes the following: Generalized Anxiety Disorder, Schizophrenia, Unspecified, and Mild Intellectual Disability. R2's Minimum Data Set, dated dated dated [DATE] documents the following: Brief Interview of Mental Status score of 12 out of a possible 15, indicating moderate cognitive impairment. R2's Health Status Note dated 12/15/24 at 9:50 am documents the following: Resident was smacked in the left arm by another resident this morning. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145584	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Mattoon	1000 Palm 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	On 12/27/24 at 3:15 pm V13 (Licensed Practical Nurse) stated I am the only person that witnessed (R1) hit (R2). I reported it immediately as abuse because it was deliberate. (R1) dropped the plastic cover to his motorized wheelchair remote control. He was on his way to the dining room. I was right there and picked it up. (R2) was trying to squeeze through a one-foot opening between (R1's) wheel chair and the wall. (R1) was already agitated that he dropped the plastic cover. He started smacking her (R2's) arm repeatedly, maybe three or four times. At first, (R2) was surprised and did not know why (R1) hit her. Then she acted like nothing had happened. I separated them right away and made sure (R2) was ok. We continued to monitor them both. I passed this on in report. R1 gets agitated at himself, but I have not seen him upset with another resident like he was with her (R2). The facility state surveying agency Final Investigation Report dated 12/20/24 documents the following: Summary: On 12/15/2024 (R2) was trying to squeeze through the doorway and (R1), (in order) to enter the dining room and (R1) hit (R2). The staff immediately separated the residents from each other and assessed (R2). They found no visible injuries. On 12/27/24 at 3:20 pm V1 (Administrator/Abuse Prevention Coordinator) confirmed R1 hit R2. The facility Abuse Prevention Policy dated February 2021 documents: This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined below. Definition: Physical Abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. The same policy documents: This facility is committed to protecting our residents from abuse by anyone including but not limited to, facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145584	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Mattoon	1000 Palm 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on observation, interview, and record review the facility failed to provide a dependent resident assistance with dressing and hygiene needs. This failure affects one of three residents (R4) reviewed for assistance with activities of daily living on the sample list of 14. Findings include: R4's current Diagnoses sheet documents the following: Morbid Obesity, Severe (80-100 pounds over the desired body weight) Due to Excessive Calories, and Diabetes Mellitus Type II with Diabetic Autonomic (Poly) Neuropathy (nerve damage that causes pain, numbness, tingling, swelling and weakness in different parts of the body) R4's Minimum Data Set (MDS) dated [DATE] documents R4 has a Brief Interview of Mental Status score of 12 out of a possible 15, indicating moderate cognitive impairment. The same MDS documents R4 requires Supervision and touching assistance to meet his hygiene needs. R4's Care Plan dated 12/05/24 documents the following: Focus: Incontinent: Check q (every) 2 (two) hours and as required for incontinence, as resident requires. Wash, rinse and dry perineum. Change clothing PRN (as needed) after incontinence episodes. Focus: Activities of Daily Living (ADL's): Self-care deficit-needs supervision and/or one assist to complete quality care and/or poorly motivated to complete ADLs. Date Initiated: 07/30/2024. On 12/30/24 at 2:04 pm V32 (Registered Nurse at Vascular Clinic) stated R4 had an appointment at the clinic on 12/09/24. V32 stated she called the facility and spoke with V15 (Agency Licensed Practical Nurse/LPN) to report that R4 arrived at the appointment with wet clothes, an unkept appearance, and skin breakdown. On 12/27/24 at 2:33 pm R4 was seated in a recliner in his room watching television. R4 had a tee shirt on with remnants of food under his chin, down the center of his shirt and over his abdomen. R4 had a strong foul odor of feces and urine. R4 stated he got messy at breakfast and lunch, and will likely get messy at supper, and doesn't have the energy to change his clothes all day. R4 also stated I have to take myself to the bathroom and change my own clothes, because staff are busy. They don't have time to help me. On 12/27/24 at 2:37 pm V9 (Agency LPN) acknowledged R4's clothes were soiled. V9 stated R4 toilets himself and changes his own clothes. V9 assisted R4 to the bathroom and pulled down his soiled pants and incontinence brief. R4's pants and shirt were wet and incontinence brief was soiled with feces. V9 did not wash R4 or change his soiled brief or clothes. V9 stated V9 would have to get a Shower Assistant to provide R4 a shower. V9 pulled up R9's soiled brief and pants and walked R4 back to his recliner chair to wait for the shower assistant. R4 was assisted to a seated position in recliner, in the same soiled brief and soiled clothes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145584	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Mattoon	1000 Palm 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/27/24 at 2:50 pm V10 (Certified Nursing Assistant/CNA/ Shower Aide) stated There is another resident (unidentified) in the shower with a CNA (unidentified). I heard (R4) needs help now. V10 gathered supplies and entered R4's room. V10 assisted R4 to the bathroom, washed her hands and donned gloves. V10 assisted R4 with removing R4's incontinent brief. V10 stated V10 will need to get R4 cleaned up and change R4's soiled clothes. R4 stated That sure will be nice. I appreciate your help. V10 removed R4's clothes while R4 sat on the toilet. The lower back of R4's tee shirt was wet, as were R4's sweatpants. The front of R4's tee shirt center was soiled with dried food. The inner back hem of R4's tee shirt was also soiled with feces. V10 removed R4's soiled brief, and soiled clothes. V10 washed her hands and donned clean gloves. V10 dressed R4 from the waist down, pulling R4's clean pants and incontinent brief over R4's bilateral swollen compression bandaged legs. V10 then stated she will have to put a clean shirt on R4 after V10 cleans R4's back and peri- areas. V10 stated It looks like we should be helping him more. I thought (R4) was independent. On 01/02/25 at 8:30 am V15 (Agency LPN) stated received a phone call 12/09/24 from V32 (Registered Nurse/RN) at R4's from the doctors' office. V32 said that R4 went to that appointment with soiled clothes and saturated in urine. V15 stated she thought night shift woke him up that day (12/9/24) and R4 did not have time to changed himself and get dressed for his appointment (scheduled 7:00 am). He should have had help. On 01/02/25 at 11:00 V22 (LPN/Care Plan/MDS Coordinator) stated the following: (R4) was never totally independent with his toileting needs. (R4) was already supposed to be supervised and helped with incontinence care and dressing, when needed. I will update his care plan so that it is clear he is to be taken to the bathroom by staff, so he is not left to do it himself.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145584	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Mattoon	1000 Palm 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 0684 Level of Harm - Minimal harm or potential for 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** 31642 Based on observation, interview, and record review the facility failed to complete skin assessments after skin impairment was identified (12/09/24), failed to measure new skin impairment, failed to obtain wound treatment orders in a timely manner, and failed to obtain a physician order prior to applying medication to a resident's skin impairment. These failures affect one of four (R4) residents reviewed for skin impairment/treatments on the sample list of 14. Findings include: R4's current Diagnoses sheet documents the following: Morbid Obesity, Severe (80-100 pounds over the desired body weight) Due to Excessive Calories, and Diabetes Mellitus Type II (DMII) with Diabetic Autonomic (Poly) Neuropathy. R4's Minimum Data Set (MDS) dated [DATE] documents R4 has a Brief Interview of Mental Status score of 12 out of a possible 15, indicating moderate cognitive impairment. The same MDS documents R4 requires supervision and touching assistance with hygiene needs and has occasional incontinent with urine. R4's Care Plan updated 12/05/24 documents areas included the following: Focus: Skin Integrity: Resident has other potential/actual impairment to skin integrity related to obesity, mobility impaired, DMII. Follow facility protocols for treatment of injury. Weekly skin check by nurse and documentation Focus: Bladder Function: The resident has bladder incontinence which can cause impaired skin integrity and needs monitored. Brief Use: The resident uses disposable briefs. Change q (every) 2 (two) hours and prn (as needed), as resident requires. Incontinent: Check q 2 hours and as required for incontinence as resident requires. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes. Focus: Activities of Daily Living (ADLs): Self-care deficit-needs supervision and/or one assist to complete quality care and/or poorly motivated to complete ADLs. Date Initiated: 7/30/2024. R4's Shower Sheet dated 11/18/24 documented by V28 (Certified Nursing Assistant/CNA) documents R4 had redness in groin areas, applied Nystatin powder. R4's Medical Record does not document R4 has an order for Nystatin to treat his groin redness. R4's Shower Sheet dated 12/19/24 documented by V34 (CNA) documents R4 had gaulding in perineal areas. V34 indicated by circles on a body map, that gaulding was on R4's front and back perineal areas. The same shower sheet documents powder was applied. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145584	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Mattoon	1000 Palm 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/2/25 at 3:05 pm V34 (CNA) verified R4's shower sheet 12/19/24 that documents powder was applied to R4's gaulded areas. V34 stated R4's had a really red stomach flap, leg creases and buttocks. V34 stated The nurse (unidentified) gave (V34) Nystatin to put on. I can't remember which nurse because all the nurses just give the Nystatin to us (CNAs) to apply. R4's Medical Record does not document R4 has an order for Nystatin to treat his gaulding perineal areas. On 12/30/24 at 2:04 pm V32 (Registered Nurse/RN at Vascular Clinic) stated R4 had an appointment at the clinic on 12/09/24. V32 stated she called the facility and spoke with V15 (Agency Licensed Practical Nurse/LPN) to report that R4 arrived at the appointment with wet clothes, an unkept appearance, and skin breakdown. V32 also stated when speaking with V15, V32 told V15 that R4's impaired skin condition on his groin needs some kind of a physician order for treatment due to the extent of his skin impairment. On 01/02/25 at 8:30 am V15 (Agency LPN) stated she worked at 6:00 am and R4 had already left for R4's appointment. V15 stated I got a phone call a little while later from (R4) doctors' office (12/09/24). They told me he was totally saturated with urine, and so were his clothes and wheelchair. I don't exactly remember if the doctor's office told me he had skin breakdown. I should have checked him out (completed a skin assessment) when he got back (from appointment). When someone is that wet, for any length of time, it would only follow he could have skin breakdown. I did not check his skin when he got back. I did ask the CNAs (unidentified) to help him get cleaned up when he returned. They never said he was red or anything. On 12/27/24 at 2:33 pm R4 was seated in a recliner in his room watching television. R4 stated he has a lot of discomfort sometimes from the rash R4 has on his privates. R4 stated Sometimes I don't feel any pain at all. The CNAs (Certified Nursing Assistants) sometimes put a cream on the rash after my shower every week. That does feel better. I can't do the cream myself. I am too (overweight). I do the best I can on my own to go to the toilet. I can't stand very long because of the issues with my lower legs. On 12/27/24 at 2:37 pm V9 (LPN) assisted R4 up from his recliner and walked beside R4 to the bathroom. R4 was incontinent of bowel and bladder. R4 had dried feces and a large amount of urine in his disposable brief and on his buttocks, low back, and scrotum. R4's right groin under leg crease had eight inches by five inches of red, raw skin with a patch of approximately one-inch-long strip of yellow and white pus-like drainage. R4 had a pannus (flap of excess abdominal skin and fat) that hung over to R4's groin area. V9 lifted R4's pannus flap and R4 had red raw skin that expanded approximately 24 inches across and four inches down his abdomen and down to R4's groin area. R4's left groin and the leg crease was also red. R4 stated to V9 that his skin is pretty tender, he would appreciate some cream or powder be put on him. V9 told R4 that V9 would get the shower aid to come get him for a shower and they will put something on his skin once they get R4 cleaned up. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145584	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Mattoon	1000 Palm 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/27/24 at 2:50 pm V10 (CNA/Shower Aide) stated the shower room was not available. V10 thoroughly cleaned R4's anterior and posterior peri-areas, pannus fold, and upper inner thighs. Under R4's dried stool on his bilateral buttocks, R4's skin was visibly irritated and red. R4's buttocks crease and coccyx were raw and bleeding. V10 stated Oh, my goodness he is bleeding. R4's scrotum was red. R4's right groin leg crease was red and had an open area, with drainage. R4's pannus and left upper groin were red and irritated. R4 then stated Could you please put some of that cream on there for me. I would really appreciate that. V10 washed hands and left R4's room. V10 returned with a container of Miconazole Nitrate 2.0 percent antifungal powder. V10 applied the antifungal powder to all R4's impaired skin areas on his groin area, coccyx and buttocks, including the open areas on R4's right groin and raw bleeding areas of R4's buttock crease and coccyx. V10 stated CNAs are allowed to put on this Nystatin powder or barrier cream. Those are both in our storage room. I did not know the antifungal was an actual medication. I don't know if it needs an order for it or not. Nurses know we put it on the residents and have never said anything. V10 stated I will report all these sores to my nurse (V9 LPN). On 12/31/24 at 11:55 am V2 (RN) reviewed R4's chart and confirmed there is no skin assessment or progress note documenting R4's skin breakdown on his groin, buttocks, coccyx or abdominal fold and no orders for those treatments. On 12/31/24 at 4:40 pm V1 (Administrator) stated I guess I have, to go back to (unit) and tell them to get (R4's) skin assessment, and treatment order again. That was supposed to be taken care of when I started my investigation (R4's alleged neglect, 12/27/24). R4's Skin Only Evaluation dated 12/31/24 at 11:07 pm, four days after V9 (LPN) was aware of R4's skin impairment, documents R4 has redness of the groin, coccyx, and under abdominal fold. No measurements are documented. On 01/02/25 at 11:50 am V21 (Medical Director/MD) stated V21 does not recall being notified of (R4's) skin breakdown. V21 stated in general V21 expects to be notified. V21 stated the Nurse Practitioner can be notified as well, so there are explicit treatment orders to address specific skin issues. The facility should have accurate documentation. V21 also confirmed without a provider treatment order, the facility should not be treating R4's skin impairment, until there has been a skin assessment and a treatment order obtained. R4's Treatment Administration Record (TAR) dated 12/1/24-12/31/24 documents that a treatment order (Nystatin Powder) was not added to treat R4's abdominal fold, and groin until 12/31/24, four days after the skin impairment was observed on 12/27/24 by V9 (LPN) with a start date/time of 12/31/2024 at 11:30 pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145584	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Mattoon	1000 Palm 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 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** 31642 Based on observation, interview and record review, the facility failed to complete a skin assessment with measurements and accurate description, obtain a pressure ulcer treatment order in a timely manner, and obtain a physician order before applying medication to a pressure ulcer. These failures affect one of four residents (R4) reviewed for skin impairment/treatments on the sample list of 14. Findings include: R4's current Diagnoses sheet documents the following: Morbid Obesity, Severe (80-100 pounds over the desired body weight) Due to Excessive Calories, and Diabetes Mellitus Type II (DMII) with Diabetic Autonomic (Poly) Neuropathy. R4's Minimum Data Set (MDS) dated [DATE] documents R4 has a Brief Interview of Mental Status score of 12 out of a possible 15, indicating moderate cognitive impairment. The same MDS documents R4 requires supervision and touching assistance with hygiene needs and has occasional incontinent with urine. R4's Care Plan updated 12/05/24 documented areas included the following: Focus: Skin Integrity: Resident has other potential/actual impairment to skin integrity related to obesity, mobility impaired, DMII. Follow facility protocols for treatment of injury. Weekly skin check by nurse and documentation. R4's Shower Sheet dated 11/18/24 documented by V28 (Certified Nursing Assistant/CNA) documents R4 had redness in groin areas, applied Nystatin powder. R4's Medical Record does not document R4 has an order for Nystatin to treat his groin redness. R4's Shower Sheet dated 12/19/24 documented by V34 (CNA) documents R4 had gaulding in perineal areas. V34 indicated by circles on a body map, that gaulding was on R4's front and back perineal areas. The same shower sheet document powder was applied. On 1/2/25 at 1/2/25 at 3:05 pm V34 (CNA) verified R4's shower sheet that documents powder was applied to R4's gaulded areas. V34 stated R4 had a really red stomach flap, leg creases and buttocks. V34 stated The nurse (unidentified) gave (V34) Nystatin to put on. I can't remember which nurse because all the nurses just give the Nystatin to us (CNAs) to apply. R4's Medical Record does not document R4 has an order for Nystatin to treat his gaulding perineal areas. On 12/30/24 at 2:04 pm V32 (Registered Nurse/RN at Vascular Clinic) stated R4 had an appointment at the clinic on 12/09/24. V32 stated she called the facility and spoke with V15 (Agency Licensed Practical Nurse/LPN) to report that R4 arrived at the appointment with wet clothes, an unkept appearance, and skin breakdown. V32 also stated when speaking with V15, V32 told V15 that R4's impaired skin condition on his groin needs some kind of a physician order for treatment due to the extent of his skin impairment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145584	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Mattoon	1000 Palm 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/02/25 at 8:30 am V15 (Agency LPN) stated she worked at 6:00 am and R4 had already left for R4's appointment. V15 stated I got a phone call a little while later from (R4) doctors' office (12/09/24). They told me he was totally saturated with urine, and so were his clothes and wheelchair. I don't exactly remember if the doctor's office told me he had skin breakdown. I should have checked him out when he got back. When someone is that wet, for any length of time, it would only follow he could have skin breakdown. I did not check his skin when he got back. I did ask the CNAs (unidentified) to help him get cleaned up when he returned. They never said he was red or anything. On 12/27/24 at 2:33 pm R4 was seated in a recliner in his room watching television. R4 stated he has a lot of discomfort sometimes from the rash R4 has on his privates. R4 stated Sometimes I don't feel any pain at all. The CNAs (Certified Nursing Assistants) sometimes put a cream on the rash after my shower every week. That does feel better. I can't do the cream myself. I am too (overweight). I do the best I can on my own to go to the toilet. I can't stand very long because of the issues with my lower legs. On 12/27/24 at 2:37 pm V9 (LPN) assisted R4 up from his recliner and walked beside R4 to the bathroom. R4 was incontinent of bowel and bladder. V9 acknowledged R4's skin breakdown on his abdomen, buttocks, and coccyx. V9 told R4 a shower aide would give R4 a shower and a treatment would be applied after he was cleaned up. On 12/27/24 at 2:50 pm V10 (CNA/Shower Aide) stated the shower room was not available. V10 thoroughly cleaned R4's anterior and posterior perineal areas, pannus fold (excess skin and fat hanging from the lower abdomen), and upper inner thighs. Under R4's dried stool on his bilateral buttocks, R4's skin was visibly irritated and red. R4's buttocks crease and coccyx were raw and bleeding. V10 stated Oh, my goodness he is bleeding. V10 completed R4's incontinence care, left R4's room and returned with a container of Miconazole Nitrate 2.0 percent fungal powder. V10 applied the fungal powder to all R4's impaired skin areas including R4's open pressure ulcers on R4's coccyx and buttocks. V10 stated CNAs are allowed to put on this Nystatin powder or barrier cream. Those are both in our storage room. I did not know the antifungal was an actual medication. I don't know if it needs an order (physician) for it, or not. Nurses know we put it on the residents and have never said anything. There was no physician order for Nystatin, or any pressure ulcer treatment for R4's opened bleeding coccyx. On 12/31/24 at 11:55 am V2 (RN) reviewed R4's chart and confirmed there is no skin assessment documentation of R4 skin breakdown on his grown, buttocks, coccyx or abdominal fold and there are no orders for treatments. On 01/02/25 at 10:50 am V2 (RN) reviewed R4's physician orders, and plan of care. V2 stated By definition, a Stage II pressure ulcer is an open area over a bony prominence (R4's coccyx shows just that). We now have a pressure ulcer treatment order from the Nurse Practitioner (V33). The delays in incontinence care and delay in obtaining a proper treatment order most certainly resulted in (R4's) skin impairment. On 12/31/24 at 4:40 pm V1 (Administrator) stated I guess I have, to go back to (unit) and tell them to get (R4's) skin assessment, and treatment order again. That was supposed to be taken care of when I started my investigation (R4's alleged neglect, 12/27/24 related to delayed incontinence care and skin treatments). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145584	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Mattoon	1000 Palm 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's Skin Only Evaluation dated 12/31/24 at 11:07 pm, four days after V9 (LPN) was aware of the skin breakdown, documents R4 has redness of the groin, coccyx, and under abdominal fold. No measurements are documented. The same evaluation also documents a non-blanchable Stage I pressure ulcer injury .3 centimeters (was open by surveyor observation 12/27/24 documented above) on R4's coccyx. R4's Formal Pressure Ulcer Risk Assessment was not completed until 12/31/24, and documents R4 is at high risk of developing pressure ulcers. R4's Treatment Administration Record (TAR) dated 12/1/24-12/31/24 documents a treatment order that was not added to treat R4's pressure ulcer until 12/31/24, to begin on 01/01/25. R4's pressure ulcer treatment order documents: Cleanse open area to coccyx with wound cleanser, apply collagen alginate then bordered foam. Change q (every) 3 days and prn (as needed) one time a day every 3 day(s) for wound healing. On 01/02/25 at 11:50 am V21 (Medical Director) stated there are explicit treatment orders to address specific skin issues. Nystatin should not be applied to a pressure ulcer. The Nurses are to complete the assessments, obtain an order and do the treatments. The facility should have accurate documentation. V21 also confirmed without a provider treatment order, the facility should not be treating R4 skin impairment, until there has been a skin assessment and a physician ordered treatment obtained. The facility policy Decubitus Care/Pressure Areas dated January 2018 documents the following: Policy: It is the policy of this facility to ensure a proper treatment program has been instituted and is being closely monitored to promote the healing of any pressure ulcer. Responsibility: Licensed Nursing Personnel Procedure: Upon notification of skin breakdown, the QA form for Newly Acquired Skin Condition will be completed and forwarded to the Director of Nurses. 2) The pressure area will be assessed and documented on the Treatment Administration Record or the Wound Documentation Record. 3) Complete all areas of the Treatment Administration Record or Wound Documentation Record. i) Document size, stage, site, depth, drainage, color, odor, and treatment (upon obtaining from the physician). ii) Document the stages of the pressure ulcer as follows: (a) Suspected deep tissue injury: purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145584	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Mattoon	1000 Palm 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(b) Stage I: redness, which does not resolve 30 minutes after pressure is relieved, no broken skin (c) Stage II: broken skin, an abrasion, blister or shallow crater. The same policy documents: 4) Notify the physician for treatment orders. The physician's orders should include: i)Type of treatment ii)Frequency treatment is to be performed iii)How to cleanse, if needed iv)Site of application v)No PRN order is acceptable for a pressure ulcer. The order must have specific frequencies. vi)Initiate physician order on treatment sheet 5)Documentation of the pressure area must occur upon identification and at least once each week on the TAR or Wound Documentation Form. The assessment must include: i)Characteristic (i.e. size, shape, depth, color, presence of granulation tissue, necrotic tissue, etc.) ii)Treatment and response to treatment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145584	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Mattoon	1000 Palm 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 0689 Level of Harm - 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** 31642 Based on interview and record review the facility failed to adequately supervise a resident with a history of falls and complete a thorough fall investigation for one of three residents (R3) reviewed for falls on the sample list of 14. Failing to supervise R3 resulted in R3 falling and suffering fractures. Findings include: R3's Current Diagnoses Sheet documents the following: Unspecified Dementia, Severe With Other Behavior Disturbance, Generalized Anxiety, Primary Insomnia, Unsteady On Feet, and History of Falling. R3's Minimum Data Set date 12/03/24 documents R3 has severe cognitive impairment. R3's Care Plan History (hx) dated as revised 07/26/2024, documents the following: Falls: Resident does not understand mobility limits due to cognitive limitations. She has a hx (history) of falls with major to min (minor) injury. She is unsafe to use a wheelchair or walker d/t (due/to) severe cognition impairment. She tolerates ambulating holding the hand of a staff for directional purposes. Her impaired cognition and weakness put her at high risk for falls. On 12/27/24 at 1:30 pm V5 (Certified Nursing Assistant/CNA) stated I got here about 6:00 am (11/22/24). I was told in report that morning that (R3) had not slept all night. She (R3) was still up. I could tell she was really, tired. I took her to the dining room for breakfast. I laid her in the recliner, by the nurses' station first thing, after she (R3) ate (breakfast). She fell right to sleep. (R3) was sleeping, good. I was going to leave her in the recliner at lunch and feed her when she woke up on her own. (V1 Administrator) had said even if residents are sleeping, we have to bring them to the dining room to make sure they eat. We were told everybody needs to be up and in the dining room every meal. I got (R3) up and in her wheelchair. (R3) was really antsy and fidgeting in her chair. She was trying to stand up. I reminded her it was time to eat thinking that would help settle her a little bit. I took her to the dining room. I think I locked her wheelchair. She was still real tired when I got her up for lunch. (R3) was really anxious again and fidgeting in her chair. She was shaking the arms of her wheelchair the last time I saw her in there (dining room). There were other residents in the dining room then, but no staff. I had to go back down the hall to get the other resident up and out to eat. The other staff were also getting people up. I saw activity people bringing some residents to the dining room too. I think (V7 Activity Assistant) is one of their names. I left to get another resident. I was about halfway down the hall. The residents at (R3's) table are not alert and oriented. (R7) and (R8) are (alert and oriented). They were seated across from (R3) a couple tables away. (R7) is the one that screamed '(R3) fell . ' I think it was (V6 CNA) and (V14 Licensed Practical Nurse) that got to (R3) first, and maybe (V7 Activities). (R3) was on the floor and bleeding. (V2 Registered Nurse) came and put a dressing on her (R3) head. I could see she (R3) was real hurt. I felt bad. I wish I would have stayed with her in the dining room when I saw her shaking the arms of her wheelchair. I could have talked to her and calmed her down. I was focused on getting everybody down my hall up for lunch. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145584	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Mattoon	1000 Palm 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 0689 Level of Harm - Actual harm Residents Affected - Few	(Witness R7's) Minimum Data Set, dated dated dated [DATE] documents R7's Brief Interview of Mental Status score of 15 out of a possible 15, indicating no cognitive impairment. On 12/27/24 at 2:07 pm R7 stated I (R7) am the one (resident) that yelled that (R3) was on the floor. There were no staff in the dining room at the time. Staff would come in and out and did not seem to notice (R3) was agitated. I had been watching her as she became more restless over the course of time that we sat in the dining room. I can't tell you how long we were waiting for our meal. Some days it is 15 or 20 minutes and other times it can be closer to an hour. That day I can't specifically say. Even if it was only 15 minutes, (R3) was restless the whole time. She was in the dining room when I came in, so I can't be sure how long she had been there. I saw her stand up from her wheelchair, take one step, and went down immediately. I had to scream, very loud for somebody to come. An activity person (unidentified) and a nurse (unidentified) were in the dining room within probably 15 seconds. It all happened so quick. You could tell (R3) was in pain and bleeding. A bunch of other staff came in to help with her too. An ambulance was here within a few minutes. (R3) was sent to the hospital for treatment. On 12/31/24 at 3:30 pm V7 (Activity Assistant) stated Yes, I responded to (R7's) yell that (R3) had fallen (fell). I was the first person into the dining room when (R3) fell . There wasn't any staff around. (R3) was laying on the floor face down, with her feet up against the wheelchair. Her feet were freely moving it (the wheelchair) because the wheelchair was not locked. It looked like she went over the side of the wheelchair. I moved the wheelchair, so her feet wouldn't get caught. I then went and got a nurse (unidentified). (R3) is a known fall risk. There is supposed to be staff in the dining room always watching the residents. There wasn't that day. Had there been somebody, maybe her fall could have been prevented. If her wheelchair was locked, she might have had a better chance of not falling too. No one asked me to make a statement, or they would have known these things. R3's Final Investigation Report dated 12/02/24 to state surveying agency regarding R3's fall 11/22/24 was provided with witness statements. There is no documentation of V7 (Activity Assistant) being interviewed and no documentation of R3's wheelchair being unlocked. R3's same Final Fall Investigation Report dated 12/02/24 documents the following: Root cause: IDT (Interdisciplinary Team) has determined the cause of the fall is due to (R3) is not aware of safety limitations due to cognition status and self-transferred due to incontinence. Intervention- Resident (R3) will be toileted prior to meals and frequently to ensure resident is dry. Staff with be in-serviced (educated) on leaving (R3) in the dining room unattended. PT/OT (Physical Therapy/Occupational Therapy) will eval (evaluate) and treat upon returning to the facility. (R3) had an [NAME] (open reduction-surgical procedure) to Right femur on 11/24/24. (R3) has a splint to her R (right) arm for a proximal humerus fracture. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145584	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Mattoon	1000 Palm 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 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/31/24 at 11:55 am V2 (Registered Nurse/RN) stated she responded to R3's fall in the dining room, after hearing some kind of noise. She was third staff in the dining room at time. (R3's) head was bleeding from a laceration on her head. I (V2) applied a pressure dressing and cleaned the area, while two CNAs (unidentified) were getting vital signs. The two CNA said the floor nurse (unidentified) was calling 911. The ambulance came and (R3) was transferred to the gurney for transport to the hospital. V2 also stated I come in early in the morning to make sure the residents are all up and out for breakfast. That came from me (direction for all resident to be in the dining room for meals). We are addressing residents left in bed. The CNAs have been told all residents come to the dining room, unless there are issues that require them to remain in their beds. I was told after the fall, (R3) had not slept the night before. That would be a circumstance CNAs would relay to the nurse, so (R3) could continue to sleep. There is to be a CNA, always in the dining room, while the other staff are getting the other residents out for meals. We discussed, during morning meeting the next day (after R3's 11/22/24 fall), that there was no one in the dining room, supervising the residents. That should never have happened. Her (R3's) fall could have been prevented. On 12/31/24 at 4:00 pm V14 (Licensed Practical Nurse/LPN) stated I did not witness (R3's) fall. I came out of my office when I heard (R7) yell for help. (R3) was lying flat on her stomach, with the right side of her face on the floor. She was very tense and never talked. The wheelchair was already moved away from (R3's) feet, so I don't know if it was locked or not. I heard she (R3) was really groggy when they got her out of the recliner to bring her to the dining room that day. I think it was (V19 Social Service Director) that called 911. R3's AIM (Assessment/Evaluation Intercommunication Management/Intervention) For Wellness- Event Record dated 11/22/2024 at 10:55 am documents the following: Late Entry: Note Text: Event Details: (R3) appears to have experienced an alleged Intentional Change in Plane; Witnessed w (with)/head involvement. Event was first noted on 11/22/2024 10:55 am Evaluation of the resident and event occurred on or about 11/22/2024 11:00 AM. Just prior to/at the time of the event (R3) appears to have been sitting in w/c (wheelchair) at the dining room table. (R3's) account of the event is unable to explain what happened. Witness to the event includes: (R7) stated she (R3) stood up from her w/c and started to walk and immediately fell to the ground hitting her head. Location of the event is: Dining room. Description of the environment at the time of the event includes quiet. Staff's immediate response is noted as Assessed resident, VS (vital signs) taken, EMS (Emergency Medical Service) called. Unable to determine if this type of event is known to have occurred previously. R3's Hospital Emergency Documentation signed by V29 (emergency room /ER Physician) dated 11/22/24 at 12:54 pm documents the following: Chief Complaint: Patient to the ED (Emergency Department) via EMS (Emergency Medical Service) from (Facility) for (an) unwitnessed fall. Patient (R3) was in dining room, stood from her wheelchair, and fell . Laceration to right forehead skin tear to right upper arm. History of Present Illness: This is a [AGE] year-old female brought to the emergency room by ambulance from (facility name) nursing home for a complaint of a fall with right hip pain. The patient herself is quite demented so I am unable to get any history from her. According to the chart the patient was in the dining room and stood up from her wheelchair and fell . I am unable to get any details from the patient due to her dementia, no other description of the fall was given. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145584	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Mattoon	1000 Palm 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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Systems: Review of systems is unobtainable other than what is stated in the HPI (history of present illness). Physical Exam: Vital signs reviewed. In general, the patient is awake, pleasantly demented, appears in no acute distress. Pupils are equal, sclera clear, TMs (Tympanic Membrane's/eardrum) normal, nares are pink, oropharynx is clear. The patient's right upper forehead has a 2 cm (two centimeter) vertical superficial abrasion without any surrounding soft tissue swelling or hematoma. Neck has no midline tenderness or step deformities. Heart is regular rate and rhythm without murmurs. Lungs are clear. Abdomen is soft, nondistended, with active bowel sounds. Extremities shows shortening and external rotation to the right lower extremity. The patient has significant tenderness palpation of the right hip. There is no tenderness to the knee or ankle on that side. Her right upper extremity at the mid bicep triceps area shows a 1-1/2 cm superficial skin tear without any bruising or hematoma formation. The patient has marked tenderness to palpation of the proximal and mid right humerus and there is crepitance, shoulders, elbows, and wrists are nontender and have no deformity. Palpation of her chest wall and ribs shows no tenderness or deformity. The same report documents: ED Course: An x-ray was performed of the patient's right hip that I reviewed. The patient has a displaced intertrochanteric right hip fracture. I did order baseline labs. X-ray of the right humerus shows a comminuted and mildly angulated and displaced fracture to the proximal humerus below the humeral head. A CT (Computed Tomography) of the brain without contrast was performed and I reviewed the images myself. There is atrophy and periventricular lucencies but I do not see any evidence of bleed or midline shift. Still awaiting radiology report. I did contact (V30 Physician) from orthopedics, and he will consult. He feels that the humerus fracture will be nonoperative and the hip will be operative repair. I spoke with (V31 Nurse Practitioner) from the hospital service and the above was discussed with her. She does agree to admit the patient for her right humerus and right hip fractures with orthopedics consulting. I did have nursing staff placed the right upper extremity in a long-arm sugar-tong splint. Baseline labs were drawn. The facility Fall Prevention policy dated 11/18/17 documents the following: Policy: To provide for resident safety and to minimize injuries related to falls; decrease falls and still honor each resident's wishes/desires for maximum independence and mobility. The same policy documents direct all staff 'must observe residents for safety.' If residents with are observed up or getting up, help must be summoned, or assistance must be provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145584	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Mattoon	1000 Palm 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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on observation, interview and record review, the facility failed to provide timely incontinence care for one of three residents (R4) reviewed for incontinence care on the sample list of 14. Findings include: R4's Minimum Data Set (MDS) dated [DATE] documents R4 has a Brief Interview of Mental Status score of 12 out of a possible 15, indicating moderate cognitive impairment. The same MDS documents R4 requires supervision and touching assistance with hygiene needs and has occasional incontinent with urine. R4's Care Plan updated 12/05/24 documents the following: Focus: Bladder Function: The resident has bladder incontinence which can cause impaired skin integrity and needs monitored. Brief Use: The resident uses disposable briefs. Change q (every) 2 (two) hours and prn (as needed), as resident requires. Incontinent: Check q 2 hours and as required for incontinence as resident requires. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes. Focus: Activities of Daily Living (ADLs): Self-care deficit-needs supervision and/or one assist to complete quality care and/or poorly motivated to complete ADLs. On 12/27/24 at 2:33 PM R4 was seated in a recliner in his room watching television. R4 had a strong foul odor of feces and urine that permeated R4's room. R4 stated he had not gone into the bathroom since before breakfast today. R4 also stated I have to take myself to the bathroom and change my own clothes, because staff are busy. They don't have time to help me. On 12/27/24 at 2:37 PM V9 (Licensed Practical Nurse/LPN) stated R4 toilets himself and changes his own clothes. He is independent. V9 then walks down to R4's room and acknowledges the strong foul feces and urine odor. V9 assisted R4 out of his recliner and walked beside him as he ambulated with a wheeled walker. R4 stood in the front of the toilet and asked V9 if she could help R4 pull down his incontinence brief. R4's incontinence brief was soiled with feces and large amount of urine. R4's brief also had the cotton filling pulled away from the plastic liner sporadically and was totally saturated with urine. R4 had dried feces visible on his bilateral buttocks and up at the top of his buttocks crease. R4's low back, waist high, and inner tee shirt had dried feces present. R4's lower buttocks crease was full of smashed, soft appearing feces. V9 did not provide incontinence care. V9 pulled up R4's soiled incontinence brief and wet sweatpants. V9 told R4 that V9 would send a Shower Assistant in to get him into the shower. V9 walked R4 back to his recliners, and assisted R4 to a seated position. R4 continued seated in the same soiled brief and soiled clothes while he waited for a shower assistant to provide incontinence care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145584	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Mattoon	1000 Palm 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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/27/24 at 2:50 PM V10 Certified Nursing Assistant/CNA/Shower Aide) stated There is another resident (unidentified) in the shower with a CNA (unidentified). I heard (R4) needs help now. V10 gathered supplies and entered R4's room. V10 assisted R4 to the bathroom, washed her hands and donned gloves. V10 assisted R4 with removing R4's incontinent brief. V10 stated V10 will need to get R4 cleaned up and change R4's soiled clothes. R4 stated That sure will be nice. I appreciate your help. V10 removed R4's lower clothes while R4 sat on the toilet. The lower back of R4's tee shirt was wet, as were R4's sweatpants. The front of R4's tee shirt center was soiled with dried food. The inner back hem of R4's tee shirt was soiled with feces. V10 removed R4's soiled brief, and soiled clothes completed incontinence care and noted R4 had excoriated pannus, groin, buttocks, and coccyx. V10 stated It looks like we should be helping him more. I thought (R4) was independent. On 12/30/24 at 2:04 PM V32 (Registered Nurse/RN at Vascular Clinic) stated R4 came to an appointment on 12/09/24, from the facility, with urine-soaked clothes and skin impairment. V32 stated she notified V15 (Agency Licensed Practical Nurse/LPN) that same day. On 01/02/25 at 8:30 am V15 (Agency LPN) confirmed V32 (RN) had notified V15 that R4 had come to his appointment 12/09/24 in urine-soaked clothing. V15 stated R4 usually takes care of himself and changes his own brief and his own clothes. On 12/31/24 at 2:35 PM V 17 (CNA) stated R4 is independent with his care, therefore V17 did not know R4 had skin impairment on his groin. On 12/31/24 at 4:00 PM V14 (LPN) stated as far as she knew, R4 was independent with toileting and dressing. On 01/02/25 at 11:00 AM V22 (LPN/Care Plan/MDS Coordinator) stated the following: (R4) was never totally independent with his toileting needs. (R4) was already supposed to be supervised and helped with incontinence care and dressing, when needed. I will update his care plan so that it is clear he is to be taken to the bathroom every two hours by staff, so he is not left to do it himself. The facility Toileting General Procedure dated 3/15/23 documents the following: Policy: To ensure safe toileting opportunities are provided to meet resident needs. Responsibility: All nursing personnel. The same policy directs staff to assess the resident's need to toilet through verbal or behavioral cues and/or established pattern, and to provide peri- care as described per procedure and plan of care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145584	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Mattoon	1000 Palm 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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642 Based on observation, interview, and record review the facility failed to employ a full-time Director of Nurses (DON) and failed to have Registered Nurse (RN) coverage eight consecutive hours per day seven days a week for four of 14 days in a two week period. These failures have the potential to affect all 86 residents in the facility. Findings Include: Upon survey entrance and throughout the survey (12/27/24- 01/02/25) there was no Director of Nurses working in the facility. On 12/27/24 at 1:10 PM V2 (Registered Nurse) stated the facility has not employed a full time Director of Nurse for months. On 12/27/24 at 3:20 PM V1 (Administrator) confirmed the facility has not employed a Director of Nursing for several months. On 01/02/25 at 11:40 am V24 (Nurse Scheduler/ Human Resources) confirmed the schedule for the past two weeks. V24 stated the following: (V2 RN) does not work the floor. Though the nursing schedule has her on it. She comes in part-time and does background office work. (V25 RN) is our only RN. He was off 12/20/24, 12/26/24, 12/27/24 and 12/31/24 he requested off. V24 confirmed We did not have RN coverage of eight consecutive hours a day, and we have not had a Director of Nursing (DON) since (V26 DON) left 10/11/24. The facility's Facility assessment dated [DATE] (not updated) documents the facility will be staffed according to resident's needs and required staffing guidelines. The Facility Assessment documents the facility will employ a full-time Director of Nurses. The facility Resident Roster by Room dated 12/27/24 documents 86 residents reside in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145584	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Mattoon	1000 Palm 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 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ staff that are licensed, certified, or registered in accordance with state laws. 31642 Based on observation, interview, and record review the facility failed to ensure qualified licensed staff apply Nystatin (medication antifungal powder) for one of four residents (R4) reviewed for skin impairment/treatments on the sample list of 14. Findings include: On 12/27/24 at 2:33 PM R4 was seated in a recliner in his room. R4 stated I have a lot of discomfort sometimes from the rash I have on privates. Sometimes I don't feel any pain at all. The CNAs (Certified Nursing Assistants) sometimes put a cream on the rash, after my shower every week. That does feel better. I can't do the cream myself. I am too (overweight). I do the best I can, on my own, to go to the toilet. I can't stand very long because of the issues with my lower legs. On 12/27/24 at 2:50 PM V10 (CNA/Shower Aide) assisted R4 to the bathroom and provided incontinence care. R4's right groin, under leg crease had eight inches by five inches of red, raw skin with a patch of approximately one inch strip of yellow white pus-like drainage down the center. R4 had a large pannus that hung over and touched R4's groin area. R4's belly fold skin was red and raw skin and expanded approximately 24 inches across R4's lowered abdomen and four inches down. R4's left groin and the leg crease was red. R4's scrotum was red. R4's buttocks was visibly irritated and red. R4's upper buttocks crease and coccyx were raw and bleeding. V10 stated Oh, my goodness he's bleeding. R4 then stated Could you please put some of that cream on there for me. I would really appreciate that. V10 washed hands and left R4's room. V10 returned with a container of Miconazole Nitrate 2.0 percent antifungal powder (generic Nystatin Powder). V10 applied the medicated antifungal powder to all R4's impaired skin areas on his groin areas, belly fold, bleeding coccyx, and buttock crease areas. V10 stated CNAs are allowed to put on this Nystatin powder or barrier cream. R4's Shower Sheet dated 11/18/24 documented by V28 (CNA) documents R4 had redness in groin areas, and applied Nystatin powder. R4's Physician Orders do not document a treatment order for Nystatin until 12/31/24 during survey. R4's Shower Sheet dated 12/19/24 documented by V34 (CNA) documents R4 had gaulding in perineal areas. V34 indicated by circles on a body map, that gaulding was on R4's front and back perineal areas. The same shower sheet documents powder was applied. R4's Physician Orders do not document a treatment order for R4's gaulding, until 12/31/24, during survey. On 01/02/25 at 11:50 am V21 (Medical Director/MD) confirmed Certified Nursing Assistants should not be applying Nystatin medication skin treatment powder. The nurses are to complete the resident skin assessments, obtain the treatment orders and complete the skin treatments. On 01/02/25 at 3:05 PM V34 (CNA) verified R4's shower sheet above, dated 12/19/24 which documents powder was applied to R4's gaulded areas. V34 stated R4's had a really red stomach flap, leg creases and buttocks. V34 stated The nurse (unidentified) gave (V34) Nystatin to put on. I can't remember which nurse because all the nurses just give the Nystatin to us (CNAs) to apply. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145584	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Mattoon	1000 Palm 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 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility policy Medication Administration dated 11/18/17 documents the following: Policy: Drugs and biologicals are administered only by physicians and licensed nursing personnel. Definition: Drug administration shall be defined as an act in which a single dose of a prescribed drug or biological is given to a resident by an authorized person in accordance with all laws and regulations governing such acts. The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's orders, giving the individual dose to the proper resident, and promptly recording the time and dose given. Responsibility: Licensed nursing personnel. The facility policy Conformance with Physician Medication Orders dated 9/27/17 documents the following: Policy: All medications, including cathartics, headache remedies, or vitamins, etc., shall be given only upon the written order of a physician. All such orders shall have the handwritten signature of the physician. (Rubber stamp signatures are not acceptable). These medications shall be given as prescribed by the physician and at the designated time. Responsibility: Licensed Nursing personnel.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145584	A. Building B. Wing	01/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Mattoon	1000 Palm 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 31642 Based on interview and record review the facility failed to maintain complete and accurate medical records for a resident that was out of the facility at a doctor's appointment. This failure affects one of eight residents (R4) reviewed for complete/accurate medical records on the sample list of 14. Findings include: On 12/30/24 at 2:04 PM V32 (Registered Nurse/RN at the Vascular Clinic) stated R4 came to the Vascular Clinic for an appointment 12/09/24 at 7:00 am. V32 stated she called the facility and spoke to V15 (Agency Licensed Practical Nurse/LPN). V32 stated she informed the facility that R4 had arrived for his appointment unkept, saturated in urine and with skin impairment of R4's groin. V32 stated the facility was informed R4 had no treatment order for this skin impairment but will need a physician to order one. On 12/31/24 at 11:55 am V2 (RN) reviewed R4's chart. V2 confirmed there is no documentation to indicate R4 went out to an appointment to vascular center on 12/09/24. There is no documentation of R4's return, there is no documentation that R4 was soiled with incontinence at the appointment or had skin impairment of R4's groin. V2 also confirmed there was no treatment order documented for R4's impaired skin on his groin. On 01/02/25 at 8:30 am V15 (Agency LPN) stated she did not even know R4 was out of the building when she came into work at 6:00 am on 12/9/24. She did not receive information in report from night shift, and there was no documentation in R4's chart that he was gone to an appointment. V15 also stated I guess he left for a venous study of some sort, just before I came in that day. I was looking for him an hour or so later, to give him his (R4) meds (medication). (V20 Certified Nursing Assistant) told me he was gone. V15 also stated I got a phone call a little while later from the doctors' office. They told me he was totally saturated with urine, and so were his clothes and wheelchair. V15 confirmed she had not written a note about R4 being out of the facility, documented when he returned, documented that the vascular center called about R4 being saturated in urine with skin impairment, completed a skin assessment or obtained treatment order from the physician. On 01/02/25 at 11:50 am V21 (Medical Director) stated the facility should have completed R4's skin assessment, maintained accurate documentation and called for specific treatment orders for R4's skin impairment.