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	01/29/2026

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 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 provide a clean, homelike environment for four (R2, R52, R56, R77) out of five reviewed for physical environment in a sample list of 39 residents.Findings include:The facility was unable to provide any documentation of maintenance requests or completion reports for repairs requested or completed.On 1/20/26 at 11:25 AM, R2's wall next to her closet showed a large area of dents and scratches measuring approximately three feet wide by one foot tall. R2 did not have a closet door in place.On 1/20/26 at 11:38 AM, R52's closet did not have a door. The wall behind R52's dresser had five nails protruding approximately one inch from the wall.On 1/20/26 at 11:40 AM, R56's wall next to the head of her bed showed multiple scratches and dents covering an area approximately two feet wide by one foot tall.On 1/27/26 at 10:15 AM, R56 stated she would like her wall to be repaired. R56 stated, I always like a room to look neat and well taken care of.On 1/28/26 at 9:15 AM, V45 (Maintenance Assistant) stated there is no process in place for the maintenance department to know what needs to be repaired. V45 stated there used to be request slips staff would complete, but now staff verbally notify V1 (Administrator) who then informs the maintenance staff. V45 stated nothing is written down, making it difficult to keep track of repairs.On 1/28/26 at 9:50 AM, R52 stated it would be very nice to have her room repairs made. R52 stated she never lived at home like this and would like the repairs to her wall to be made. R52 also stated she would like to have a closet door so that her room looked neater.On 1/28/26 at 10:43 AM, R77's mattress showed a large wet area in the center. V44 (Certified Nursing Assistant/CNA) shined a flashlight on the area and observed the top layer of the mattress was very worn and thin.On 1/28/26 at 10:45 AM, V44 stated R77 has to lie on a wet bed every night. V44 stated the outer lining of R77's mattress is so worn that it allows urine to seep through the top of the mattress. V44 stated that even if R77 is wearing dry clothes and is not incontinent of urine, once R77 sits on his bed, his clothes become saturated with urine from the mattress.On 1/28/26 at 11:00 AM, V30 (Housekeeper) stated the facility uses a chemical spray to clean the mattresses. V30 stated the spray degrades the surface of the mattress, causing urine to remain on the surface and soak into the mattress underneath.On 1/29/26 at 9:30 AM, V18 (Regional Registered Nurse), stated the facility previously had a paper system in place for maintenance to document requests and completed repairs. V18 stated V1 (Administrator) did away with that system and instead had staff verbally report maintenance needs to her, which she then relayed to the maintenance department. V18 stated the facility is returning to the previous paper system to better track maintenance requests and the completed repairs.The undated Illinois Long Term Care Ombudsman Resident Rights pamphlet documents that residents have the right to a clean and homelike environment.

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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to protect a resident's right to be free from staff to resident physical and emotional abuse which caused skin tears to the resident's arm and severe emotional distress. This failure affected one of three residents (R93) reviewed for abuse on the sample list of 39. Findings Include: The facility's Abuse Prevention Program dated February 2021 documents that the facility affirms residents' rights to be free from abuse. This includes freedom from physical restraint, mistreatment, or abuse of any resident. Abuse is defined as the willful infliction of injury, intimidation, or punishment resulting in harm, pain, or mental anguish. Willful means the individual acted deliberately; it does not require intent to inflict injury or harm.R93's Medical Diagnoses list dated January 2026 documents diagnoses of Congestive Heart Failure, right and left above-the-knee amputations, neuromuscular bladder dysfunction, generalized anxiety, depression, and a pressure ulcer of the buttocks.R93's Minimum Data Set (MDS) dated [DATE] documents R93 is cognitively intact, has no documented behaviors, requires substantial to maximum assistance with rolling side to side, and is dependent on staff for toileting hygiene. R93 has a urinary catheter and is always incontinent of bowel.R93's Abuse Final Report dated 1/13/26 documents R93 reported that two night-shift Certified Nursing Assistants (CNAs), V34 and V35, were rough with him during care. Both CNAs were agency staff and were not permitted to return to work at the facility.On 1/20/26 at 11:30 AM, R93 was observed sitting in his wheelchair in his room. R93 had a dressing on his right forearm. R93 stated that approximately one week prior, during the early morning hours, two CNAs entered his room to provide incontinent care. R93 stated he requires staff assistance with incontinence care due to bilateral lower-extremity amputations. R93 stated he did not know the identities of the two CNAs, had never seen them prior to that night, and had not seen them since. R93 stated the CNAs called him derogatory names and pinned him down in bed by holding his arms. R93 stated he was incontinent with a large amount of diarrhea and that both CNAs were upset with him for requiring cleanup. R93 stated one CNA had very long fingernails, which caused skin tears on his arms. R93 stated he became very upset and yelled at the CNAs, calling them names. R93 stated he then took a drink of his pop, and the same CNA who had held his arms down struck his hand so hard that the drink flew out of his hand. R93 stated V1 (Administrator) informed him the two CNAs had been suspended and would not work at the facility again.On 1/28/26 at 1:29 PM, V25 (CNA) stated she arrived at work at 6:00 AM on 1/13/26 and heard R93 yelling from his room. V25 stated she went directly to R93's room and observed him crying uncontrollably. V25 stated she had never previously seen R93 cry and described him as extremely distraught. R93 told V25 he intended to report the night-shift CNAs for abuse and mistreatment. V25 stated it took some time for R93 to calm down. V25 stated R93 told her one CNA held his arms down and tore the skin on his arm. V25 stated she examined R93's arms and observed two fresh skin tears on his left arm, both shaped in a manner consistent with fingernail injuries. V25 stated R93 reported the CNAs removed the pillow from under his head while changing him and that after the incident, he told them to leave his room. V25 stated R93's bedding and pillow were covered in feces and feces were present on the floor. V25 stated R93 told her when he attempted to take a drink of his pop, the CNA who held his arms down struck the bottle, causing it to fly across the room. V25 stated the pop was dried and sticky on the floor, and the bottle was located across the room. V25 stated R93 admitted he yelled profanities at the CNAs because he was upset about how he was treated. V25 stated she had never known R93 to act in that manner, does not believe R93 makes false allegations, and stated R93 typically allows staff to provide care and does not refuse assistance. V25 stated R93 only (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	wants to be treated respectfully and does not want to be left lying in his own feces.On 1/28/26 at 1:53 PM, V36 (Registered Nurse/RN) stated she was asked to complete a skin assessment on R93 following an allegation of abuse occurring on 1/13/26. V36 stated R93 reported night-shift CNAs grabbed his arms, held him down, and that a CNA's fingernails tore his skin. V36 stated she observed dried blood on R93's left arm. V36 observed a skin tear on the left forearm and, adjacent to it, a crescent-shaped indentation that broke the skin and had blood present. V36 stated the injury appeared consistent with a fingernail.On 1/28/26 at 2:00 PM, V34 (Agency CNA) stated she worked with R93 on the night shift between 1/12/26 and 1/13/26. V34 stated she and another CNA (V35) entered R93's room to provide care and that R93 became upset. V34 stated R93 became combative and admitted she held his wrists down on the bed. V34 stated R93 was so upset that they were unable to complete care and left him soiled until the next shift.On 1/29/26 at 10:11 AM, V2 (Director of Nursing) stated staff should never antagonize a resident or restrain a resident by holding their arms. V2 stated R93 is typically very cooperative with staff and does not become upset when treated respectfully. V2 confirmed R93 is not known to make false allegations. V2 confirmed R93 alleged emotional and physical abuse and stated staff should never treat a resident in that manner.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect a resident (R81) from misappropriation of personal property by another resident (R74). This failure affects two residents (R74 and R81) out of six reviewed for misappropriation on the sample list of 39.Findings include: On 1/20/26 at 4:05 PM, R74 freely admitted he had picked up cigarettes and vape cartridges that did not belong to him. R74 stated the facility nursing staff keep smoking materials at the nurses' station and place them on the counter when it is time to smoke. R74 further stated he walked up to the nurses' station counter, observed cigarettes and vape cartridges without names on them, and picked them up. R74 also stated his own cigarettes and vape cartridges had gone missing.R74's Care Plan, initiated on 12/16/25, documents behavioral problems related to misappropriation of property belonging to others (vapes, lighters, and smoking materials).R74's Minimum Data Set (MDS) assessment dated [DATE] documents R74 is cognitively intact, with a Brief Interview for Mental Status (BIMS) score of 14 out of a possible 15.On 1/21/26 at 1:24 PM, V1 (Administrator) stated there were allegations of R74 taking other residents' cigarettes and vape cartridges. V1 stated nursing staff would retrieve the materials as soon as R74 picked them up. V1 stated nursing staff maintain smoking materials in a locked cabinet, place them out when it is time to smoke, and lock them back in the cabinet when smoking time is over. V1 stated she was aware R81 was one of the residents whose vape cartridges were missing due to R74 taking them. V1 further stated V12 (Licensed Practical Nurse/LPN), kept vape cartridges in her car to replace R81's vape cartridges when R74 took them. V1 concluded by stating each resident must purchase their own vape cartridges or cigarettes using their personal funds.On 1/21/26 at 1:24 PM, V13 (Human Resources Director) confirmed V1's statements regarding R74 taking other residents' vape cartridges. V13 stated the situation involved R74 approaching the nurses' station, picking up vape cartridges, and as he walked away, nursing staff would say, Let me see what's in your hand, to which R74 would jokingly respond, Which hand?On 1/21/26 at 2:41 PM, V14 (Former Facility Certified Nursing Assistant/CNA), stated the theft of cigarettes and vape cartridges had been occurring for over six months. V14 identified R74 as the primary perpetrator of the thefts of smoking materials. V14 concluded by stating the missing smoking items constituted theft and that theft is abuse.On 1/21/26 at 2:53 PM, R81 stated she was familiar with R74 and that R74 had stolen at least four vape cartridges from her. R81 stated she turned in her vape cartridges to be locked up after smoking time, but when she returned at the next smoking time, the vape cartridges were missing. R81 stated when she informed staff her vape cartridges were missing, staff always found them in R74's possession. R81 stated when her vape cartridges were missing, it took between one day and a couple of days before they were returned. R81 stated there were no occasions when staff caught R74 at the time he picked up her vape cartridges; otherwise, they would not have been missing at the next smoking time. R81 stated staff returned the vape cartridges to her but expressed concern because she did not know who had been using them. R81 stated on one occasion staff found R74 outside smoking her vape cartridge and sharing it with a group of four residents. R81 stated facility administration replaced her vape cartridge with a new one on two occasions. R81 concluded by stating she was aware she was not the only resident from whom R74 had taken vape cartridges.R81's Minimum Data Set (MDS) assessment dated [DATE] documents R81 is cognitively intact, with a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15.On 1/22/26 at 10:56 AM, V16 (CNA), stated he had knowledge of R74 taking vape cartridges from other residents. V16 stated he had observed R74 in the common area near the nurses' station and that R74 typically waited for an agency nurse to be on duty. V16 stated R74 would watch until the nurse left the nurses' station, then gain access (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the cabinet where smoking materials were kept. V16 stated on one occasion R74 spider monkeyed (climbed) over the nurses' station counter to access the cabinet. V16 stated the cabinet had not historically been locked because access behind the nurses' station was controlled by a locked doorway; however, some agency nurses left the door unlocked, allowing R74 access to the cabinet. V16 stated locking the cabinet was a new intervention implemented to prevent R74 from taking vape cartridges. V16 stated vape cartridges were missing for periods ranging from eight hours to a couple of days.The facility Abuse Prevention Policy dated 2/2021, provided by V1 (Administrator) documents the facility affirms residents' rights to be free from abuse, including misappropriation of resident property. The policy defines misappropriation as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report all allegations of misappropriation of resident's personal property to the state surveying agency. This failure affects two residents (R74 and R81) out of six reviewed for misappropriation on the sample list of 39.Findings include:On 1/20/26 at 4:05 PM, R74 stated he had picked up smoking materials, including cigarettes and vape cartridges, that did not belong to him. R74 also stated his own cigarettes and vape cartridges had gone missing.R74's Care Plan, initiated on 12/16/25, documents behavioral problems related to misappropriation of property belonging to others (vapes, lighters, and smoking materials).On 1/21/26 at 1:24 PM, V1 (Administrator) stated there had been allegations of R74 taking other residents' cigarettes and vape cartridges. V1 stated she had been told by regional corporate staff that if the facility retrieved the items at the same time they were taken, it was not considered theft. V1 stated she did not report the allegations of misappropriation to the state surveying agency based on the instructions of regional corporate staff. V1 stated she was aware R81 was one of the residents whose vape cartridges were taken by R74.On 1/21/26 at 1:24 PM, V13 (Human Resources Director) confirmed the statements made by V1.On 1/21/26 at 2:41 PM, V14 (Former Facility Certified Nursing Assistant/CNA), stated he had direct knowledge of R74 taking other residents' cigarettes and vape cartridges. V14 stated R74 had been taking these items for over six months. V14 stated he and other staff had reported the misappropriation to the Administrator but were told that if R74 did not smoke all the cigarettes or use the vape cartridges until they were empty, it was not considered theft and did not need to be replaced or reported.On 1/21/26 at 2:53 PM, R81 stated R74 had taken her vape cartridges on at least four occasions. R81 stated she reported the missing items to staff, including V42 (Former CNA), V17 (Psychiatric Rehabilitation Services Assistant), and V16 (CNA). R81 stated her vape cartridges were missing for periods ranging from one day to a couple of days. R81 stated there were no occasions when staff returned her vape cartridges immediately because she turned her vape cartridges in to nursing staff to be supposedly locked in a cabinet; however, when she returned at the next smoking time, the vape cartridges were missing. R81 stated staff always found her vape cartridges in the possession of R74.On 1/22/26 at 10:56 AM, V16 (CNA) stated he had direct knowledge of R74 taking vape cartridges from other residents. V16 stated he and other staff verbally reported the incidents to the Administrator (V1) on multiple occasions and reported one incident via text message. V16 stated on each occasion the vape cartridges were missing for periods ranging from eight hours to a couple of days.On 1/28/26 at 3:30 PM, V27 (Regional Nurse Consultant) provided a single report to the state surveying agency regarding R74 stealing vape cartridges, dated 12/10/25.The facility's Abuse Prevention Policy dated 2/2021, provided by V1 (Administrator) documents that all alleged violations, including misappropriation of resident property, shall be reported to the state surveying agency and investigated according to the facility's established investigative process.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to allow one (R11) resident the opportunity to choose a destination facility in his involuntary discharge process out of three residents reviewed for discharges in a sample list of 39 residents.Findings include: R11's undated Face Sheet documents R11 was admitted to the facility on [DATE].R11's Electronic Medical Record (EMR) documents medical diagnoses of paraplegia, moderate protein-calorie malnutrition, thoracic spinal cord injury (T7-T10), opioid dependence, neuromuscular dysfunction of the bladder, chronic pain, traumatic brain injury, history of urinary tract infection (UTI), neurogenic bowel, and tobacco use.R11's Minimum Data Set (MDS) dated [DATE] documents R11 is cognitively intact.R11's Involuntary discharge date d 12/1/25 documents R11 would be transferred to another facility located in Illinois.On 1/20/26 at 11:30 AM, R11 stated the facility was kicking him out because he had been aggressive toward staff. R11 stated he occasionally yelled at staff because they don't do what they are supposed to do. R11 stated he had spoken with the Ombudsman and V2 (Director of Nursing/DON), regarding his concerns, stating V1 (Administrator) is the devil. R11 stated V1 had not abused him in any way but stated she should not be in charge of anything. R11 stated he lived in Kentucky prior to residing in Illinois and wanted to return to Kentucky. R11 stated the facility did not ask him where he wanted to go and did not offer him any options in Kentucky.On 1/23/26 at 1:30 PM, V1 (Administrator) stated R11 is a paraplegic resident of the facility. V1 stated V11 (Social Service Director/SSD), could no longer deal with R11 after R11 made a comment about a slip and fall to V11 while V11 was walking down the hall. V1 stated R11 had a verbal altercation with R14 on 10/27/25, which had been reviewed by the state surveying agency with no findings. V1 stated R11 was issued an involuntary discharge on [DATE]. V1 stated the facility sent referrals to multiple other facilities, one of which accepted R11. V1 stated the facility informed R11 of the accepting facility, and R11 threw a fit about not being able to choose where he was going and not being able to return to Kentucky.On 1/28/26 at 9:35 AM, V29 (Ombudsman) stated R11 was issued an emergency involuntary discharge on [DATE] by the facility. V29 stated he had spoken with R11 on multiple occasions and was told R11 wanted to return to Kentucky. V29 stated he discussed R11's wishes with V1 (Administrator) and was told, good luck. V29 stated R11 was not allowed to participate in his own discharge, as the facility did not ask R11 where he wanted to go and did not send referrals to facilities in Kentucky.On 1/28/26 at 10:00 AM, V28 (Director of Admissions) stated he assumed responsibility for R11's discharge because V1 (Administrator), and V11 (Social Service Director) no longer wanted to deal with R11. V28 stated R11 was not permitted to suggest facilities where he wanted to be discharged . V28 stated R11 was issued an involuntary discharge with an accepting facility already identified. V28 stated R11 did not choose that facility; rather, the facility independently sent the referral and informed R11 of the acceptance.The facility policy titled Transfer or Discharge, Facility-Initiated, revised October 2022, documents that residents are to be oriented and prepared for an emergent or immediate facility-initiated discharge when a complete discharge planning process is not practicable. The policy further documents nursing notes must include documentation of appropriate orientation and preparation of the resident prior to transfer or discharge.The undated Illinois Long Term Care Ombudsman Program Resident Rights pamphlet documents residents have the right to participate in their own care planning.

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to implement pressure relieving measures timely, failed to complete a thorough skin assessment weekly and failed to prevent one (R107) resident's right heel pressure ulcer from worsening to a stage IV out of three residents reviewed for pressure ulcers in a sample list of 39 residents. R107 obtained a Stage IV pressure ulcer to her right heel at the facility. Findings include:R107's undated Face Sheet documents R107 was admitted to the facility on [DATE].R107's Electronic Medical Record (EMR) documents medical diagnoses of chronic respiratory failure with hypoxia, cognitive communication deficit, vitamin D deficiency, asthma with acute exacerbation, atelectasis, iron deficiency, delusional disorder, pulmonary embolism without acute cor pulmonale, morbid obesity, cellulitis of the right lower limb, fatty liver, hepatic encephalopathy, and a right heel Stage IV pressure ulcer.R107's Minimum Data Set (MDS) dated [DATE] documents R107 is moderately cognitively impaired. The MDS further documents R107 is dependent on staff for assistance with oral hygiene, bathing, dressing, toileting, personal hygiene, bed mobility, and transfers.R107's Pressure Risk assessment dated [DATE] documents R107 was at risk for developing a pressure ulcer.R107's Nurse Progress Note dated 2/4/25 at 10:01 PM documents new open areas to R107's right heel. The note documents the right heel tissue was black with bloody drainage, red wound edges, and edema.R107's Skin-Only Evaluation dated 2/4/25 documents the plantar surface of R107's right heel had an open area measuring 0.9 cm long x 1.0 cm wide x 0.1 cm deep with bloody drainage and necrotic tissue. The evaluation further documents the posterior aspect of the right heel had an open area measuring 2.0 cm long x 2.0 cm wide, with no depth documented, and necrotic tissue with bloody drainage. The evaluation also documents R107's left heel was red, with no measurements or further assessment documented.R107's Nurse Progress Note dated 2/13/25 at 2:41 PM documents V41, Wound Physician, was notified of a wound care referral. The note documents a new physician order for R107 to wear a heel guard and that wound supplements were ordered for R107's right heel Stage III pressure ulcer.R107's EMR does not document a full wound assessment of R107's right heel pressure ulcer upon R107's return from the hospital on 2/13/25.R107's Wound Evaluation and Management Summary dated 2/20/25 documents an initial visit for R107's right heel Stage IV pressure ulcer measuring 4.0 cm long x 3.0 cm wide x 0.2 cm deep.On 1/27/26 at 3:05 PM, V10 (Licensed Practical Nurse/LPN), stated V41 (Wound Physician) saw R107 on 2/20/25 for her right heel. V10 stated she observed R107's right heel during wound rounds on 2/20/25 and that the wound appeared worse than when R107 returned from the hospital. V10 stated V41 categorized the wound as a Stage IV pressure ulcer on 2/20/25.On 1/28/26 at 11:10 AM, V7 (LPN) stated R107 had a significant pressure ulcer on her right heel. V7 stated the facility identified the wound on 2/4/25 as facility-acquired; however, R107 was hospitalized from [DATE] to 2/13/25. V7 stated R107 did not want to do anything and preferred to lie on her back in bed. V7 stated R107's heels rested directly on the bed for the majority of each day. V7 stated the facility should have obtained heel protectors upon R107's admission.On 1/28/26 at 2:10 PM, V18 (Regional Registered Nurse/RN), stated the facility was unable to provide documentation of a right heel wound assessment upon R107's readmission from the hospital. V18 stated the facility should document skin assessments, especially when a resident returns from the hospital. V18 stated the facility would provide education to nursing staff regarding timely assessments, interventions, and pressure ulcer prevention.The facility policy titled Pressure Ulcers/Skin Breakdown - Clinical Protocol, revised April 2018, documents the nurse shall describe and document a full assessment of a pressure ulcer, including location, stage, length, width, depth, and the presence of exudate or necrotic tissue. The policy further documents staff and practitioners will examine the skin (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	of newly admitted residents for evidence of existing pressure ulcers or other skin conditions.

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	01/29/2026

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide services to maintain or increase a resident's range of motion. This failure affected one of three residents (R10) reviewed for Range of Motion on the sample list of 39. Findings include:The facility's Restorative Nursing Services policy dated July 2017 documents residents will receive restorative nursing care as needed to help promote optimal safety and independence.On 1/20/26 at 1:15 PM, R10 stated that although he prefers to remain in bed most of the time, he would like staff assistance with range-of-motion and strengthening exercises to maintain the strength he still has. R10 stated staff do not ask him to participate in any restorative range-of-motion programs.R10's Minimum Data Set (MDS) dated [DATE] documents R10 is cognitively intact.R10's Physician Order Sheet (POS) dated January 2026 documents diagnoses of adult failure to thrive, lack of coordination, reduced mobility, heart failure, chronic obstructive pulmonary disease, and morbid obesity.R10's Care Plan dated 10/7/25 documents R10 has limited physical mobility and requires staff assistance with bed mobility, transfers, hygiene, and dressing. The Care Plan documents staff are to provide supportive care and gentle range of motion as tolerated. The Care Plan further documents R10 is on a Restorative Nursing Active Range of Motion Program consisting of bilateral lower-extremity range-of-motion exercises for 10 repetitions, twice daily.R10's Restorative Program documentation from November 2025, December 2025, and January 2026 documents multiple gaps (over 20 entries) with no documentation indicating restorative exercises were attempted or completed, as well as multiple entries documenting R10 as unavailable.On 1/29/26 at 10:11 AM, V2 (Director of Nursing), confirmed R10 is always in his room and consistently available for staff to complete the restorative range-of-motion program. V2 stated staff can complete the program while R10 remains in bed and should offer the program multiple times per day. V2 stated the facility employs a restorative aide; however, she stated the aide doesn't really do his job, and that the facility census requires more than one restorative aide to provide effective services.

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement fall prevention interventions and failed to maintain a safe environment for two residents (R7 and R107) out of six residents reviewed for falls in a sample of 39 residents. R107 experienced pain and fear as a result of falling, as well as a closed head injury and multiple contusions following a fall on 1/1/25. R107 required further evaluation of her injuries in an emergency room following falls on 1/1/25 and 1/8/25 due to having a physician order for Xarelto (anticoagulant therapy). Findings include: 1.R107's Electronic Medical Record (EMR) documents medical diagnoses as Chronic Respiratory Failure with Hypoxia, Systolic Heart Failure, Schizophrenia, Cognitive Communication Deficit, Vitamin D Deficiency, Atelectasis, Iron Deficiency, Delusional Disorder, Pulmonary Embolism without acute Cor Pulmonale, Morbid Obesity, Cellulitis of Right Lower Limb, and Hepatic Encephalopathy. R107's Minimum Data Set (MDS) dated [DATE] documents R107 as moderately cognitively impaired. This same MDS documents R107 as being dependent on staff for assistance with oral hygiene, bathing, dressing, toileting, personal hygiene, bed mobility and transfers. R107's Fall Care Plan initiated 12/19/24 documents the root cause of R107's falls as dizziness upon standing. R107's Care Plan intervention dated 1/4/25 documents R107 is to utilize a wheelchair. This same Care Plan documents an intervention dated 1/8/25 for staff to assist R107 to the dining room and assist R107 to a chair. This same Care Plan documents an intervention dated 2/28/25 to keep a bedside table for personal items within reach. R107's Fall Risk Evaluation dated 12/18/2024 documents R107 as being a high fall risk. R107's Physician Order Sheet (POS) dated January and February 2025 document a physician order starting 11/27/24 for Rivaroxaban (anticoagulant) 15 milligrams (mg) twice daily for Pulmonary Embolism. R107's Nurse Progress Note dated 1/1/2025 at 1:02 PM documents R107 had an unwitnessed fall in the resident common area. This same note documents R107 stated she attempted to stand, felt dizzy, fell and hit her head. This same note documents R107 was noted to have a large purple bruise on her Coccyx/Sacral area. This same note documents R107 was sent to the hospital for evaluation. R107's fall investigation dated 1/1/25 documents R107 had an unwitnessed fall in the resident common area. This same fall investigation documents R107 tried to stand up, felt dizzy and fell back and hit her head on the floor. This same investigation documents R107 was sent to the emergency room for further evaluation due to R107 takes an anticoagulant. R107's Hospital Record dated 1/1/25 documents R107 fell at the facility obtaining a closed head injury, cervical strain and contusions of her Left Knee, Right Knee, Left Forearm and Left Shoulder. R107's Nurse Progress Note dated 1/1/25 at 9:00 PM documents R107 returned to the facility. This same note documents R107 obtained a status post fall closed head injury, cervical strain, contusion of Left Knee, Right Knee, Left Forearm and Left Shoulder. This same note documents physician orders to (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	rest, apply ice, elevate affected extremities and wear ace wrap to Left Forearm and bilateral knees. R107's Nurse Progress Note dated 1/5/25 at 1:07 PM documents R107 stayed in her room all shift. This same note documents R107 stated 'I'm scared to come out because I don't want to fall. I'm not coming out.' R107's Nurse Progress Note dated 1/7/25 at 6:16 PM documents R107 refused to get out of bed unless up in a wheelchair. This same note documents R107 stated she is not coming out (of her room) due to she is scared of falling. This same note documents R107 refused to take herself to the bathroom and is choosing to soil herself. R107's Nurse Progress Note dated 1/8/25 at 12:43 PM documents R107 was walked to the dining room with staff assistance. This same note documents R107 walked over to a different chair and fell to the floor. This same note documents this fall was witnessed by V43 (Certified Nursing Assistant/CNA) who stated she 'watched (R107's) head bounce off of the floor'. R107's fall investigation dated 1/8/25 documents R107 had a witnessed fall in the facility dining room. This same fall investigation documents R107 was walking independently to move to another chair and R107 missed the chair falling to the floor and hit her head. R107's Hospital Record dated 1/8/25 documents R107 obtained a Hematoma to the posterior aspect of R107's scalp due to her falling on 1/8/25 at the facility. R107's Fall Investigation dated 2/28/25 documents R107 had an unwitnessed fall out of her bed because she was reaching for candy due to R107 did not have a bedside table. R107's fall investigation dated 2/28/25 documents R107 had an unwitnessed fall in her room. This same investigation documents R107 was found on the floor with feet towards the window and head propped up on the side of the bed. Investigation documents R107 stated 'she was reaching for a piece of candy and slid out of bed'. This same investigation documents R107 did not have any injuries. R107's Nurse Progress Note dated 3/1/25 at 5:56 PM documents the root cause of R107's unwitnessed fall on 2/28/25 as R107 was reaching for her personal items at her bedside and slid out of bed. This same note documents the intervention for R107's fall was to keep a bedside table at R107's bedside. On 1/27/26 at 3:00 PM V10 (Licensed Practical Nurse/LPN) stated R107 fell out of her bed on 2/28/25 due to R107 was trying to reach over to her bedside dresser to get some candy. V10 stated R107 did not have a bedside table in her room. V10 stated if R107 had a bedside table she would not have had to reach so far and most likely not fallen out of her bed. V10 stated it is standard for all residents to have a bedside table and there was no reason R107 did not have a table to put her personal belongings on. R107's fall on 2/28/25 could have been prevented if R107 had a bedside table. V10 stated since R107 was on a low air loss mattress R107 should have had a bedside table to prevent her from falling out of bed. On 1/28/26 at 11:05 AM V7 (LPN) stated she was R107's nurse regularly. V7 stated the staff knew R107 had been dizzy every time she stood up and 'really nothing had been done about it'. V7 stated the staff should have been monitoring R107 closer since 'we knew she was sitting on the bench, and she would be going to the dining room for lunch'. V7 stated R107 hit her head on the hard floor then (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	complained of a headache so she was sent to the emergency room. V7 stated R107 had a 'large' bruise on her Sacral area. R107's fall on 1/1/25 could have been prevented with closer supervision due to the staff knew for 'a few days' that R107 was not feeling good and complained of dizziness with standing. V7 stated R107 fell again on 1/8/25 after therapy walked R107 to the dining room but did not leave a wheelchair for her to use. V7 stated R107 was supposed to use a wheelchair at that point and she did not have one to use. V7 stated R107 wanted the wheelchair and would have used it instead of trying to walk. V7 stated R107 was scared to walk alone and would have used the wheelchair. V7 stated R107's fall on 1/8/25 could have been prevented if R107 had a wheelchair accessible. V7 stated R107 wanted to use the wheelchair due to her fear of falling again. On 1/29/26 at 9:50 AM V18 (Regional Registered Nurse/RN) stated the facility does not have any documentation to show that fall interventions were in place at the time of R107's falls. V18 stated all residents should have a bedside table. V18 stated that it is a standard piece of equipment and does not know why R107 did not have a bedside table in her room. V18 stated staff should have been supervising R107 if they had known she was complaining of being dizzy when standing. V18 stated a wheelchair should have been left with R107 in the dining room so she wouldn't have walked over to another chair. V18 stated the staff should follow the interventions put into place to help reduce a resident's falls. The facility policy titled Falls-Clinical Protocol revised March 2018 documents After a first fall, the staff (and physician, if possible) should watch the individual rise from a chair without using his or her arms, walk several paces, and return to sitting. If the individual has no difficulty or unsteadiness, additional evaluation may not be needed. If the individual has difficulty or is unsteady in performing this test, additional evaluation should occur. 2. R7's Medical Diagnoses list dated January 2026 documents R7 is diagnosed with Chronic Obstructive Pulmonary Disease, Fractured Left Tibia, Disorder of Muscles, Lack of Coordination, Gait Abnormalities, Muscle Wasting, Phantom Limb Syndrome, and Right Above the Knee Amputation. R7's Physician Order Sheet dated January 2026 documents a physician order for a left half side rail in the up position while in bed to enhance bed mobility. Staff should check positioning and functioning of device. R7's Health Status Note dated 12/17/25 documents R7 was heard yelling from her room. Staff went in to check on R7 and found her sitting on the floor by her bed. The left side rail was on the floor beside her. R7 stated she attempted to sit up on the side of the bed, using the side rail, when it fell off the bed frame, causing R7 to fall with it onto the ground. On 01/22/2026 10:45 AM V15 (Maintenance Director) stated nursing staff often remove or replace side rails on resident's beds and do not secure them to the bed frames properly. V15 stated this is what he believes happened when R7's bed rail came off the frame and caused her to fall. V15 confirmed the bed rail was not properly secured. On 1/22/26 at 3:00 PM V2 (Director of Nurses) confirmed only maintenance staff are to remove and install bedrails. V2 confirmed the bedrails need to be installed correctly to be safe and not pose a hazard for residents. V2 confirmed when R7 fell from her bed on 12/17/25, her bed rail came off the bed when she attempted to use it. V2 confirmed the bed rail must not have been secured and therefore posed a hazard which resulted in R7 falling onto the floor.

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	145584	A. Building B. Wing	01/29/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect one resident's (R88) respiratory mask from potential cross-contamination, and failed to obtain appropriate physician orders for two residents (R9 and R10) to include required pressures for operation. This failure affects three residents (R9, R10, and R88) out of three reviewed for respiratory equipment on the sample list of 39.Findings include:1. R88's Census Detail printed 1/28/26 and Diagnoses List printed 1/23/26 document R88 was admitted to the facility on [DATE] with medical diagnoses including Acute and Chronic Respiratory Failure with Hypercapnia (elevated carbon dioxide levels), Chronic Congestive Heart Failure, Morbid Obesity with Alveolar Hypoventilation (lungs do not expand enough to fill adequately), Insomnia, and Obstructive Sleep Apnea (stops breathing when asleep).R88's Physician Order Sheet printed 1/23/26 documents R88 is to use the BIPAP ventilator while sleeping, with the inspiratory pressure set at 14 and the expiratory pressure set at 6.On 1/22/26 at 12:49 PM, R88's BIPAP (non-invasive ventilator) mouth mask was observed sitting in direct contact with a small table surface at the foot of R88's bed. The mouth mask was not inside any type of protective covering.On 1/22/26 at 12:49 PM, R88 stated she requires staff assistance with placing and removing her BIPAP mask.On 1/22/26 at 3:11 PM, V2 (Director of Nursing) observed and confirmed R88's mask was sitting in direct contact with the table surface without protective covering. V2 stated the facility's practice was to place BIPAP masks in a plastic bag. V2 further stated there had previously been a plastic bag in R88's room containing several BIPAP masks and tubing, which was not present at that time. V2 concluded the plastic bag may have been picked up by the respiratory company representative on Tuesday (1/20/26) when a new mask was delivered to R88.2. R9's Diagnoses List printed 1/23/26 documents R9 has medical conditions including Chronic Bronchitis, Asthma, Morbid Obesity, Obstructive Sleep Apnea, and Chronic Congestive Heart Failure.R9's Physician Order Sheet printed 1/23/26 documents R9 has a physician order to wear a BIPAP while sleeping. This BIPAP order does not include inspiratory or expiratory pressure settings.3. R10's Diagnoses List printed 1/23/26 documents R10 has medical diagnoses including Chronic Obstructive Pulmonary Disease, Acute Respiratory Failure with Hypoxia (low oxygen), Acute and Chronic Congestive Heart Failure, Morbid Obesity, Obstructive Sleep Apnea, Pulmonary Hypertension, Tachypnea (rapid breathing rate), and Insomnia.R10's Physician Order Sheet printed 1/23/26 documents R10 has a physician order to wear the BIPAP as tolerated and to maintain IPAP (Inspiratory Positive Airway Pressure); however, no pressure setting is listed in the order. On 1/28/26 at 3:15 PM, V18 (Regional Nurse) stated she would obtain new physician orders specifying BIPAP settings for R9 and R10.The facility's policy titled CPAP/BIPAP (Continuous Positive Airway Pressure/Bi-level Positive Airway Pressure) Support, dated March 2015, documents nursing staff are to review the physician's order to determine the prescribed oxygen concentration and flow, as well as pressure settings, including CPAP, IPAP (Inspiratory Positive Airway Pressure), and EPAP (Expiratory Positive Airway Pressure), for the machine.

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	145584	A. Building B. Wing	01/29/2026

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, interview, and record review the facility failed to obtain informed consent for use of bilateral bed rails. The facility also failed to safely and securely install bed rails and failed to maintain safe and secure bed rails for one of six residents (R7) reviewed for accident hazards on the sample list of 39. Findings Include: The facility's Bed Safety and Bed Rails policy dated August 2022 documents that bed rails must be properly installed. To use bed rails, the facility must obtain informed consent.R7's Medical Diagnoses List dated January 2026 documents R7 is diagnosed with Chronic Obstructive Pulmonary Disease, Fractured Left Tibia, Disorder of Muscles, Lack of Coordination, Gait Abnormalities, Muscle Wasting, Phantom Limb Syndrome, and Right Above-the-Knee Amputation.R7's Physician Order Sheet dated January 2026 documents a physician order for a left half side rail in the up position while in bed to enhance bed mobility. Staff are to check the positioning and functioning of the device.R7's Bed Rail Transfer Bar Consent dated 2/7/25 documents R7 provided consent to use a left half side rail.R7's Health Status Note dated 12/17/25 documents R7 was heard yelling from her room. Staff entered the room and found R7 sitting on the floor next to her bed. The left side rail was on the floor beside her. R7 stated she attempted to sit up on the side of the bed using the side rail when it fell off the bed frame, causing R7 to fall to the floor with it.On 1/22/26 at 10:40 AM, R7's bed had both a right and left half side rail present. The right-side rail was loose and moved significantly from side to side.On 1/22/26 at 10:45 AM, V15 (Maintenance Director) stated nursing staff often remove or replace side rails on residents' beds and do not secure them to the bed frames properly. V15 stated this is what he believed occurred when R7's bed rail came off the frame and caused her fall. V15 confirmed the bed rail was not properly secured. V15 further confirmed R7's bed currently had two bed rails present and that the right-side rail was not secured properly. The right-side rail was loose and posed a hazard. V15 removed the right-side rail and stated R7 only had a physician order and consent for a left-side bed rail. V15 stated he was unsure who installed the right-side rail, but it should not have been on R7's bed.On 1/22/26 at 3:00 PM, V2 (Director of Nursing) confirmed only maintenance staff are permitted to remove and install bed rails. V2 confirmed bed rails must be installed correctly to ensure safety and prevent hazards to residents. V2 confirmed that when R7 fell from her bed on 12/17/25, the bed rail came off the bed frame when R7 attempted to use it.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide a sufficient number of Licensed Nurses and Certified Nursing Assistants staff to meet the residents' needs for safety and quality of care. This failure has the potential to affect all 94 residents residing in the facility. Findings Include: The Facility assessment dated [DATE] documents an average daily census of 80-85 residents. The facility's goal is to maintain sufficient staffing to ensure an adequate number of qualified staff are available to meet each resident's needs.The Daily Nursing Schedule for 1/24/26 and 1/25/26 documents that on the night shift of 1/24/26 there was one nurse and one Certified Nursing Assistant (CNA) assigned to the front half of the building. On the day shift of 1/25/26, there was only one nurse in the building until 11:00 AM, when a second nurse arrived.On 1/29/26 at 8:45 AM, V37 (Licensed Practical Nurse/LPN) stated she was the front hall nurse on the night shift of 1/24/26. V37 stated she was alone in the front of the building for approximately one and a half hours, from 10:00 PM to 11:30 PM, before any other staff arrived. V37 confirmed she did not feel this staffing level was safe or in the best interest of the residents. V37 stated that at the end of her shift, she needed to leave and there was no one available to replace her. V37 stated V2 (Director of Nursing/DON) agreed to come in to work; however, V2 lived nearly an hour away and had to be plowed out of her driveway due to winter weather. V37 stated she left at 8:00 AM and handed her keys to the back hall nurse, who then became the only nurse on duty in the entire building.V37 further stated she is always the only nurse assigned to the front halls at night. She typically has one CNA and one unit aide. The unit aide works from 10:00 PM to 4:00 AM. V37 stated that from 4:00 AM to 6:00 AM, the front halls require two CNAs to assist residents with toileting and morning care. During this time, she begins her early morning medication pass and is unable to consistently assist the sole CNA.On 1/29/26 at 10:11 AM, V2 (DON) confirmed staffing levels from 1/24/26 to 1/25/26 were very low due to winter weather conditions. V2 stated she came to the facility Sunday morning to cover the shift and arrived close to 11:00 AM. V2 confirmed V40 was the only nurse in the building from 8:00 AM until nearly 11:00 AM. V2 stated staffing shortages are an ongoing issue. V2 confirmed the facility utilizes multiple agency staff members who frequently call off, resulting in the facility being short-staffed.On 1/29/26 at 11:24 AM, V40 (LPN) stated she worked the day shift on 1/25/26. V40 stated she was the only nurse in the building from 8:00 AM until 11:00 AM, when V2 (DON) arrived. V40 stated she was assigned to the back halls of the building. V40 confirmed that the morning was particularly stressful, as a resident in the front hall experienced a seizure and fell to the floor. V40 stated the facility is often short-staffed, especially on weekends. V40 stated she feels resident care suffers when staffing is inadequate and resident safety is compromised. V40 stated nurses are unable to perform their duties effectively and must rush through tasks when staffing levels are insufficient.