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	04/20/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to protect resident's right to be free from resident-to-resident verbal abuse. This failure affected one of six residents (R1) reviewed for abuse on the sample list of six. Findings Include:The facility's Abuse, Neglect, Exploitation, and Misappropriation Prevention Program Policy, dated April 2021, documents that each resident has the right to be free from abuse, including but not limited to verbal abuse.R2's Medical Diagnoses list, dated April 2026, documents that R2 is diagnosed with Major Depressive Disorder and Generalized Anxiety.R2's Minimum Data Set (MDS), dated [DATE], documents that R4 is cognitively intact, has bilateral lower extremity impairment, and uses an electric wheelchair for mobility.R2's Care Plan, dated 4/16/26, documents that R2 has the potential to be verbally aggressive related to mental and emotional illness. R2 exhibits inappropriate social behaviors, including the use of racial slurs, racist comments, and offensive gestures, which can be distressing to others.R2's Nurses Notes, dated 4/11/26, document that R2 was verbally attacking staff and residents and using racial slurs. R2 went into the smoking area and rammed his wheelchair into another resident's (R1's) chair.On 4/20/26 at 12:15 PM, R2 stated he did get into it with R1 because R1 put his two cents in where it didn't belong. R2 stated he was venting about staff to R1 when R1 laughed at him. R2 stated he then started going off on R1. R2 admitted to using the N word (racial slur) toward R1; however, he would not specify exactly what was said. R2 stated he is not racist but can get upset sometimes. R2 stated he does not want to get in any trouble. R2 stated he and R1 are not friends anymore and that is fine.R1's Medical Diagnoses List, dated April 2026, documents that R1 is diagnosed with paraplegia, chronic pain, and a personal history of traumatic brain injury.R1's Minimum Data Set (MDS), dated [DATE], documents that R1 is cognitively intact, has bilateral lower extremity impairment, and uses a manual wheelchair for mobility.On 4/20/26 at 11:45 AM, R1 stated that on 4/11/26, R2 was upset with the nursing staff and came outside to the smoking area where R1 and other residents were smoking and began venting to them. R1 stated R2 was complaining when R1 chuckled at something he was watching on his phone. R1 stated he believes R2 thought he was laughing at him because R2 then started to explode and went off on him. R2 was using profane language and racial slurs, calling R1 a N***** (expletive) lover because R1's wife is black, and his children are biracial. R1 stated he ignored R2 and tried to avoid any altercation. R1 stated R2 got in his face, moved his finger in front of him, and bumped him with his electric wheelchair. R1 stated he does not feel he should have to change his schedule to avoid R2. R1 stated that every time he goes out to smoke, he feels R2 tries to follow him. R1 wants to avoid R2 and does not want to speak to him again. R1 stated that R2 also yells at staff members and often uses racial slurs when upset. R1 stated R2 walks up and down the hallways yelling curse words and racial slurs, including saying [NAME] Hitler and making a Nazi salute. R1 stated he is not afraid of R2; however, R2's constant attempts to confront him are exhausting, and he does not want to feel uncomfortable where he lives.On 4/20/26 at 12:34 PM, R5 confirmed he was present on 4/11/26 when R2 became verbally abusive toward R1. R5 stated R2 is racist and often yells racial slurs in the hallways and toward staff. R5 stated R2 claims to be a Nazi, says [NAME] Hitler, and makes a Nazi (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	04/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Mattoon	1000 Palm Mattoon, IL 61938

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	salute. R5 stated he feels R2 tries to intimidate people and provoke reactions. R5 stated R2 had his finger in R1's face and was yelling and cursing, calling R1 a B**** (expletive) and a N***** (expletive) lover.On 4/20/26 at 12:52 PM, R4 confirmed she was present on 4/11/26 when R2 became verbally abusive toward R1. R4 stated R2 came outside to the smoking area and began venting about staff. R4 stated R2 was talking while R1 was watching videos on his phone. R4 stated R1 laughed at what he was watching, and R2 thought R1 was laughing at him. R2 then began verbally attacking R1, calling him a B**** (expletive) and a N***** (expletive) lover. R4 stated R2 rammed his wheelchair into R1's wheelchair, got in his face, and pointed his finger at him. R4 stated R1 ignored R2, but R2 continued the behavior. R4 stated she feels safe in the building but that it is concerning they must watch out for R2 because his behavior is unpredictable.On 4/20/26 at 3:30 PM, V1 (Administrator) confirmed R2 has a history of becoming verbally aggressive with other residents and is care planned for this behavior, including the use of racial slurs. V1 confirmed R2 and R1 were involved in a verbal altercation on 4/11/26. V1 stated both residents have been asked to avoid each other; however, both are cognitively intact and refuse to change their schedules to fully avoid one another. Therefore, both R1 and R2 are on 15-minute checks.