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	05/13/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to treat a resident with respect and dignity and care in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for one resident (R8) out of three residents reviewed for dignity in a sample list of 33 residents.Findings include:R8's Electronic Medical Record (EMR) documents R8's medical diagnoses as Morbid Obesity, Depression, Congestive Heart Failure, Major Depressive Disorder (MDD), Tobacco Use, and acquired absence of the right and left legs above the knee.R8's Minimum Data Set (MDS), dated [DATE], documents R8 as cognitively intact.On 5/6/26 at 1:50 PM, R8 stated he was trying to find a visitor who normally sits in the facility conference room. R8 stated the conference room door was open, and although he cannot see very well, he could see someone inside the conference room. R8 stated he started to enter the conference room when V3 (Licensed Practical Nurse/LPN) came to the door and loudly told him to get out. R8 stated V3 shut the door on him and told him to go somewhere else to look. R8 stated he was trying to find the visitor and did not understand why V3 did not help him find the person he was looking for. R8 stated he was very upset by this incident. R8 stated V3 was snotty to him. R8 stated, I don't have cooties. (V3) was being a total B---- (spelled-out expletive) to me for no reason.On 5/7/26 at 12:30 PM, V1 (Administrator) stated the facility was having a party for the nursing staff, so the conference room was full of treats and goodies for staff. V1 stated R8 was looking for a visitor and tried to enter the conference room when V3 told him to look somewhere else. V1 stated she did not think V3 was being abusive toward R8, but V3 (LPN) could have offered to assist R8 in finding the visitor without conflict.On 5/8/26 at 10:25 AM, V3 (LPN) stated she went to the conference room to get a cup of hot chocolate when R8 started to enter the conference room. V3 stated she did not know whether residents were allowed in the conference room, but the conference room table was filled with food for staff, and she did not want R8 to put his dirty hands on the food. V3 stated R8 said he was looking for someone who was not in the conference room, and she did not know where the visitor was, so she told R8 to look elsewhere. V3 stated she did try to close the conference room door but did not slam it or close it aggressively. V3 stated she could have handled the situation differently by assisting R8 in finding the person he was looking for. V3 stated this was an unfortunate situation that should not have gone there. V3 stated R8 was upset over this incident, and V1 (Administrator) was informed at the time it occurred.The facility policy titled Dignity, revised February 2021, documents that all residents have the right to be treated with dignity and respect at all times.

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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 one (R6) resident's right to be free from verbal and physical abuse from another (R7) resident with R9-R13 witnessing this incident. The facility failed to protect one resident (R5) from verbal abuse by another resident (R8). These failures affect nine residents (R5, R6, R7, R8, R9, R10, R11, R12, R13) out of nine residents reviewed for abuse in a sample list of 33 residents.Findings include:1.R6's Electronic Medical Record (EMR) documents R6's medical diagnoses as Psychosis, Major Depressive Disorder, Mood Disorder, Paranoid Personality Disorder, Adjustment Disorder, Delusional Disorder and Mild Cognitive Impairment.R6's Minimum Data Set (MDS) dated [DATE] documents R6 as cognitively intact. R7's Electronic Medical Record (EMR) documents R7's medial diagnoses as Paranoid Schizophrenia, Psychosis, Anxiety, Intellectual Disabilities, Morbid Obesity, Hallucinations, Delusions, Agitation, Aggression, Major Depressive Disorder (MDD), General Anxiety Disorder (GAD), Obsessive Compulsive Disorder (OCD) and Paranoia. R7's Minimum Data Set (MDS) dated [DATE] documents R7 as cognitively intact. R6's AIM for Wellness report dated 4/1/26 documents R6 was sitting at a dining room table involved in a group activity. There was an empty chair placed next to R6. This same report documents R7 approached and tried to move the chair. R6 did not want the chair moved so R6 held the chair so that R7 could not move the chair. This same report documents R7 hit R6 in the Left Shoulder because R6 would not let R7 move the chair.R6 and R7's combined investigation dated 4/1/26 documents written witness statements from R11, R12 and R13 all document R7 was moving chairs around as per R7's usual self when R7 got upset because R6 would not let R7 have an empty chair sitting at the dining room table where the activity was taking place. These same witness statements document V8 (Activity Director) instructed R7 to not touch the empty chair and R7 continued to try to move the chair. These same witness statements document R7 became mad, yelled at R6 and then hit R6. Witness statements from R9 and R10 document the same scenario but add that R7 called R6 a b**** (expletive) when R7 was yelling at R6 over the placement of the dining room chair. On 5/6/26 at 10:55 AM V4 (Psychiatric Rehabilitation Services Director/PRSD) stated on 4/1/26 R6 was sitting at a dining room table during an activity. V4 stated R6 had an empty chair sitting next to her. V4 stated R7 walked up to the activity table where R6 was sitting and started to take the empty chair. V4 stated V8 (Activity Director) instructed R7 the chair was not to be moved. V4 stated R7 continued to try to take the chair that R6 was holding in place. V4 stated R7 became upset and hit R6 in the Left upper Neck/Shoulder area. V4 (PRSD) stated V8 (Activity Director) should have allowed R7 to have the empty chair which would have resolved this incident without R6 being struck by R7. V4 stated R7 had no injuries and R6 had a red mark on her Left Neck/upper Shoulder area. On 5/6/26 at 11:05 AM V5 (Psychiatric Rehabilitation Services Assistant/PRSA) stated V5 was walking through the dining room at the same time R6 and R7 got into it. V5 stated V8 (Activity Director) told R7 that R7 could not have the empty chair. V5 stated R6 was holding onto the empty chair so that R7 could not use it. V5 stated this made R7 upset so R7 hit R6. V5 (PRSA) stated R9 who is R6's friend then stood up and told R7 to stop hitting R6. On 5/6/26 at 2:25 PM V8 (Activity Director) stated on 4/1/26 V8 was conducting an activity with numerous residents. V8 confirmed R6-R13 were present for the activity. V8 stated R6 was sitting next to an empty chair when R7 walked up and attempted to take the chair from R6. V8 stated V8 told R7 to not sit down and not take the chair. V8 stated R7 became more angry and yelled at R6 calling R6 a b**** (expletive) and hitting R6 on the Left Shoulder. V8 stated V8 could have stood up and walked over to R7 to redirect R7, or I should have just let (R7) sit down. V8 stated V8 told R7 to not move the chairs due to R7 moves the chairs all the time and it just scuffs the floors. On 5/7/26 at 8:55 AM R7 was laying in R7's bed in R7's room. R7 stated (R6) kept a hold of that chair. I wanted to move that chair. (R6) wouldn't let me. (V8) kept telling me to stop. (V8) told me to let go of (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the chair. I hit (R6) on the arm. I called (R6) a b**** (expletive) because (R6) is one. I haven't seen (R6) since then. I think (R6) moved. I am glad. I didn't like (R6). R7 stated R7 has not had any other concerns with other residents. R7 stated R6 was the only other resident R7 did not like. On 5/7/26 at 12:45 PM V1 (Administrator) stated the staff should have intervened between R6 and R7 prior to the incident escalating to the point of R7 hitting R6. V1 stated the staff have been trained on how to handle these kinds of situations and should have redirected R7. V1 stated we are aware that R7 moves dining room chairs frequently and should have redirected R7 as soon as R7 walked over to the table of residents. V1 stated R7 did hit R6 and it could possibly have been prevented if staff redirected R7. 2. R5's Electronic Medical Record (EMR) documents R5's medical diagnoses as Paraplegia, Opioid Dependence, Chronic Pain, Traumatic Brain Injury (TBI), Tobacco use, Unspecified injury at T7-T10 level of Thoracic Spinal Cord and Adjustment Disorder with Anxiety. R5's Minimum Data Set (MDS) dated [DATE] documents R5 is cognitively intact. R5's Care plan intervention dated 4/13/26 instructs staff to encourage R5 to avoid smoking when R8 whom R5 has previously had conflict is smoking.R8's EMR documents R8's medical diagnoses as Morbid Obesity, Depression, Congestive Heart Failure, Major Depressive Disorder (MDD), Tobacco use, Acquired absence of Right and Left Legs above the Knee.R8's Minimum Data Set (MDS) dated [DATE] documents R8 as cognitively intact. R8's Care Plan intervention dated 4/13/26 documents R8 was educated to smoke at separate times to avoid (R5) whom R8 has had previous conflict with.R5's Nurse Progress Note dated 5/10/26 at 3:16 PM documents R8 explained to V23 (Licensed Practical Nurse/LPN) that R8 was not listening to offensive music. This same note documents R8 stated the music R5 is complaining about is [NAME] in German. This same note documents R8 was counseled to be respectful of others' feelings. This same note documents R8 was sitting in the hallway in R8's wheelchair blocking R5's path to R5's room. This same note documents R5 stated R5 was upset due to R8 was blocking R5's path and staff let it happen. On 5/12/26 at 9:30 AM V1 (Administrator) stated on 5/10/26 R8 was playing R8's music which R5 did not care for. V1 stated R5 asked R8 to not play ?Nazi' music so that others have to listen to it also. V1 stated R8 then left the smoking area and went back to R8's hall. V1 stated R8 allegedly said to R5 you are a little b**** (expletive), you are a liar and you are a p****(expletive) because R5 told R8 to stop playing that kind of music. V1 stated when R8 was interviewed, R8 stated R8 can play any kind of music R8 likes and as loud as R8 likes. On 5/12/26 at 11:05 AM R5 stated R8 yelled you are a p**** (expletive), you are such a d*** crybaby (expletive) and you are a dirty rat liar at R5 on 5/10/26. R5 stated R8 and R5 were both outside smoking when R8 put R8's outstretched arm in the air like a (fascist salute) while blaring R8's music. R5 stated R5 did not engage R8 because R5 and R8 do not get along so R5 was trying to let staff solve the problem. R5 stated R8 then went down their shared hall and would not let R5 pass by R8 to get to R5's room. R5 stated R8 is a bully and the staff did not handle the problem. R5 stated the staff should have made R8 move out of R5's way so that R5 could go to R5's room but instead they (staff) are all scared of (R8) so they didn't make R8 move. R5 stated R5 turned around and went the other way and could hear R8 say you are a little b**** (expletive). On 5/12/26 at 11:35 AM V25 (Certified Nursing Assistant/CNA) stated V25 was at the nurses station on the hall where R5 and R8 both reside. V25 stated R32 and R5 both came down the hall to report that R8 was playing offensive music outside in the smoking area. V25 stated then both R5 and R32 both went back outside and shortly after R8 came down the hall to ask if R5 had reported R8 for playing R8's music too loud. V25 stated at that point, R5 had returned to the hall. V25 stated R8 yelled at R5 you are a cry baby and a rat! and you are a p**** (expletive). V25 stated R5 asked the staff (V22 CNA, V25 CNA and V23 LPN) to make R8 move so that R5 could pass by to get to R5's room. V25 stated staff asked R8 to move and R8 refused for several minutes so R5 turned around and left the hall. V25 stated R8 then finally moved to the side of the hall but R5 was already half way down the hall headed in the opposite direction by the time R8 moved. V25 stated V23 (LPN) asked R8 to be more respectful towards other residents. V25 stated R8 said some racial slurs to R5 to try to upset R5 due to R5 is married to an African-American. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V25 staff should have redirected R8 to another side of the hall and should have redirected the two (R5, R8) from smoking at the same time. On 5/12/26 at 11:45 AM V22 (CNA) stated V22 was walking out of the activity room when R33 flagged me over like it was an emergency to inform me that R8 was out to get R5. V22 stated V22 saw R5 turning R5's wheelchair around to move the opposite direction as R8. V22 stated V23 (LPN) was telling R5 that R8 had moved for R5 to get through but R5 was half way down the hall by the time R8 decided to move his wheelchair. On 5/12/26 at 11:50 AM R8 stated R8 has the right to listen to R8's music anywhere R8 wishes and as loud as R8 wishes. R8 stated R5 is always lying about R8 and causing trouble. R8 stated R8 called R5 names and kept R5 from passing R8 in the hallway so that R8 could talk with R5 about R5's claim R8 was blaring offensive music. R8 stated I have rights too. I shouldn't have to turn my music down just because other people are around. I don't care how (R5) feels. I can listen to what I want. (R5) should have been a man and talked with me that day but (R5) just ran away because (R5) is scared.On 5/12/26 at 11:55 AM R33 stated R33 was at the soda machine in the main dining room and heard R8 yelling profanities at R5 from down their shared hallway. R33 stated R8 plays his German music so loud outside nobody can talk to each other or talk to anyone on their phones. R33 stated R8 taunts other residents especially R5. R33 stated R8 claims to be a white supremacist and picks on R5 due to R5 is married to an African-American.On 5/12/26 at 12:00 PM R32 stated R32 has heard R8 claim to be a white supremacist. R32 stated R8 tries to get other residents in trouble by doing things that R8 knows upsets them. R32 stated R8 raises R8's hand in the air to show the (fascist salute) while R8 plays R8's music too loud. R32 stated R8's music does not have offensive language but R8 blares it and that along with R8's salutes it just causes a lot of drama. On 5/12/26 at 12:25 PM V23 (LPN) stated V23 was the assigned nurse for R5 and R8 on 5/10/26. V23 stated R5 was on a smoke break when R5 came back to the hall to ask staff to tell R8 to turn down R8's music due to it was offensive to R5. V23 stated R5 claimed R8 was blaring (fascist slur) music and R8 was a racist by the things R8 said to R5. V23 stated R5 then went back outside to the smoking area. V23 stated V23 went out to R5 to warn (R5) that R8 was upset with R5 and to try to avoid R8. V23 stated V23 returned to the hall and R8 was already sitting in R8's wheelchair in the middle of the hallway in front of the nurse's station. V23 stated R8 asked V23 if R5 had reported R8 for playing R8's music too loud. V23 stated R8 played the same music for the staff and there were not any recognizable words due to the music was [NAME] in German. V23 stated the staff researched the band name and lyrics and found that there was not any foul language in the songs. On 5/12/26 at 2:10 PM V13 (LPN) stated V13 witnessed a portion of the incident on 5/10/26 involving R5 and R8. V13 stated R8 was being verbally aggressive towards R5. V13 stated R5 did not engage R8. V13 stated R5 was asking the staff to move R8 out of the way so R5 could get to R5's room. V13 stated R5 couldn't get through due to R8 ignored staff's instruction to move to the side of the hall. V13 stated R8 did eventually move to the side but by that time R5 had already turned around to leave the area. On 5/13/26 at 11:00 AM V1 (Administrator) stated R5 and R8 have an ongoing issue with one another. V1 stated the facility has tried to put interventions into place to help prevent R5 and R8's altercations. V1 stated the staff could have redirected R5 and/or R8. V1 stated both R5 and R8 are care planned for staff to encourage R5 and R8 to avoid smoking at the same times. V1 Administrator stated it is a difficult situation due to R5 and R8 are both cognitively intact and both refuse to change their routines. V1 confirmed R8 yelled profanities at R5 this time and the staff should follow the resident care plan. The facility policy titled Resident Rights and Abuse Prevention Policy and Procedure Manual Abuse Prevention Policies and Procedures revised September 2022 documents abuse of any kind against residents is strictly prohibited. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting harm, pain or mental anguish. Abuse includes verbal abuse, sexual abuse, physical abuse and mental abuse including abuse facilitated or enabled through the use of technology. Physical abuse includes but is not limited to hitting, slapping, biting, bunching and kicking. Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of verbal, written or gestured communication or sounds to residents within hearing distance, regardless of age, ability to comprehend or disability. Examples of mental and verbal abuse include harassing a resident, mocking, insulting, ridiculing, yelling or hovering over a resident with the intent to intimidate.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility repeatedly failed to administer two medications to one (R2) resident causing significant medication errors out of eight residents reviewed for medication administration in a sample list of 33 residents.Findings include:R2's Electronic Medical Record (EMR) documents R2 admitted to the facility on [DATE] and discharged on 11/20/25. This same EMR documents R2's medical diagnoses as Total Left Hip Arthroplasty and revision, Anxiety Disorder, Pain due to internal Orthopedic Prosthetic Devices, Implants and Grafts, Pain in Left Hip, Infection and inflammatory reaction due to internal Left Hip Prosthesis, Joint Derangements of Left Hip and Cerebral Palsy. R2's Minimum Data Set (MDS) dated [DATE] documents R2 as cognitively intact. R2's Hospital Discharge Record dated 10/24/25 documents a physician order for Cefepime (antibiotic) 6 Grams continuously by intravenous infusion for six weeks.R2's Physician Order Sheet (POS) dated November 2025 documents a physician order starting 10/24/25 for Cefepime 6 Grams intravenously (IV) continuously every 24 hours for six weeks. This same POS documents a physician order starting 10/25/25 for Heparin Sodium Lock Flush 10 unites/milliliter (ml) 5 ml every day shift for infection after antibiotic and before starting next dose.R2's Medication Administration Record (MAR) dated November 2025 documents R2 was not administered R2's physician ordered IV Cefepime (antibiotic) on November 4, 13, 16, 18, 19 or the 20th. This same MAR documents R2 was not administered R2's Heparin Sodium 5 milliliter (ml) flush on November 4, 5, 7, 10, 13, 16, 19 or the 20th. R2's Nurse Progress Note dated 11/18/25 at 5:42 PM documents R2 came to the nurse's station to inform staff that R2 had cut the antibiotic line to (R2's) Continuous Ambulatory Delivery Device (CADD) pump last night because it was beeping. This same note documents Peripherally Inserted Central Catheter (PICC) line was still intact, flushes well and tubing noted to be in two pieces. This same note documents CADD pump could not be restarted due to no tubing/cartridge was found.R2's Nurse Progress Note dated 11/20/26 at 1:51 PM documents R2's Cefepime could not be administered due to the facility did not have the tubing for R2's CADD pump. On 5/13/26 at 12:30 PM V2 (Director of Nurses/DON) stated R2 was not administered R2's physician ordered Cefepime (antibiotic) on 11/4, 13, 16, 18, 19 and 11/20/25. V2 stated V2 could not find any documentation of why R2's antibiotic was not administered. V2 stated R2's Electronic Medical Record (EMR) documents R2 cut R2's CADD line on 11/18/25 so R2 had to have been administered the scheduled dose but that the antibiotic would not have been completed so R2 missed a partial dose. V2 stated R2 missed R2's complete doses on 11/19 and 11/20/25 due to the facility did not have the specific type of tubing required for a CADD pump. V2 stated facility nurses should administer resident medications per the physician order and if unable to do so then notify the physician and document why a resident's medication was held. V2 stated the facility should have reached out to the physician to see if another antibiotic could be administered orally or if the physician wanted to wait for the tubing to arrive from pharmacy. V2 confirmed R2's IV antibiotic was not administered per the physician order and there is no documentation to identify why it was not given. The facility policy titled Adverse Consequences and Medication Errors revised February 2023 documents a medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. This same policy documents an example of a medication error is omission when a drug is ordered but not administered.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review the facility repeatedly failed to ensure medications and narcotics were locked and stored properly for 16 (R5, R8, R14, R19-R31) residents out of 16 residents reviewed for medication storage in a sample list of 33 residents.Findings include:The facility daily midnight census documents R5, R8, R14, R19-R31 all reside on the same hallway in the facility during the survey timeframe. On 5/6/26 at 11:20 AM and 1:50 PM the facility medication cart was sitting in the hallway next to the nurse's desk unlocked. There were several residents in the area with no staff present.On 5/6/26 at 2:15 PM the same facility medication cart was unlocked sitting in the hallway next to the nurse's desk with no staff present. Several residents were sitting in close vicinity of the medication cart. V15 (Licensed Practical Nurse/LPN) walked up to the medication cart. V15 stated the medication cart should always be locked. V15 opened the first large drawer of the medication cart without using keys and showed that the lid to the narcotic box did not close completely when the medication cart drawer was closed and then opened again. V15 showed that the lid to the narcotic box could be easily opened after the drawer had been opened. V15 stated all narcotics should be locked twice to make sure someone doesn't take them. On 5/6/26 at 2:20 PM V1 (Administrator)and V2 (Director on Nursing/DON) were informed of the medication cart and narcotic box being unlocked and unattended. On 5/6/27 at 2:45 PM V16 (LPN) and V2 (DON) visually confirmed the same medication cart narcotic box lid did not lock after the medication drawer was closed. V2 stated V2 was going to call pharmacy due to the narcotic box not locking properly. V2 stated the facility should always keep all narcotics under a double lock system to ensure the safety of the medication and to help reduce the risk of theft of narcotics. On 5/7/26 at 10:55 AM V15 (LPN) stated the staff were told to make sure the narcotic box lid was completely closed. The same medication cart narcotic box lid had a handwritten note taped to the top of the lid that documents Push down on narcotic box to ensure it locks. V15 visually confirmed the same medication cart narcotic box lid did not lock after the medication drawer was closed. V15 stated the narcotic box does not lock on its own. V15 stated staff must make sure the lid is completely closed. V15 stated, some of the nurses would close the lid but there are some that aren't that careful. On 5/8/26 at 12:00 PM the same medication cart was unlocked and positioned in the main dining room with no nurses present. Multiple residents were present in the dining room.On 5/12/26 at 9:00 AM V18 (LPN) and V22 (Assistant Director of Nurses) confirmed R5, R8, R14 and R19-R31 had schedule II, schedule IV and benzodiazepines that are stored in the same medication narcotic box. On 5/12/26 at 2:40 PM V1 (Administrator) stated the same medication cart was replaced on 5/11/26 due to a faulty lock.The facility policy titled Controlled Substances revised November 2022 documents controlled substances are separately locked in permanently affixed compartments.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review the facility failed to prevent cross contamination during medication administration for three (R15, R16, R17) residents out of seven residents reviewed for Infection Control in a sample list of 33 residents.Findings include:The facility policy titled Handwashing/Hand Hygiene revised October 2023 documents staff are to perform hand hygiene immediately before touching a resident, after contact with contaminated surfaces, and after touching a resident and/or their environment. This same policy documents hand hygiene is indicated: immediately before and after touching a resident, after contact with contaminated surfaces and after touching the resident's environment. On 5/7/26 between 11:10 AM and 11:20 AM V13 (Licensed Practical Nurse/LPN) administered R15, R16 and R17's scheduled medications without washing V13's hands or using any hand hygiene before, during or after medication administration. V13 touched the medication cart, cards of resident medications, each resident (R15, R16, R17) and the dining room tables where each resident sat in between administering each resident their medications without performing hand hygiene between residents. On 5/7/26 at 11:45 AM V13 (LPN) confirmed V13 did not use any hand sanitizer or use any hand hygiene before, during or after administering medications to R15, R16 and R17. V13 stated V13 did not realize V13 needed to perform hand hygiene since V13 did not touch any of the medications. V13 stated V13 will make sure V13's medication cart has some hand sanitizer on it to help V13 to remember to use it. On 5/8/26 at 9:15 AM V2 (Director of Nurses) stated nurses should use good hand hygiene when administering medications. V2 stated nurses are expected to wash their hands if they are visibly soiled and/or use hand sanitizer between every resident to help reduce the risk of cross contamination.