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	06/05/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 protect and promote the residents' rights and ensure dignity was maintained for six residents (R1, R3, R4, R9, R10, R11) out of six residents reviewed for dignity in a sample list of 25 residents. Findings include:1. R1's Minimum Data Set (MDS), dated [DATE], documents R1 as cognitively intact.On 6/5/26 at 10:05 AM, R1 stated there was an unknown resident (R22) banging on the wall behind his closet. R1 stated that because the head of his bed is positioned directly in front of his closet, it sounded like a hammer was banging on the wall at 5:00 AM. R1 stated he turned on his light and asked V32 (Agency Certified Nursing Assistant/CNA) to move R22 so she could not reach the wall to continue banging on it.R1 stated V32 (CNA) called me a racist and told me I wasn't going to get her fired. R1 stated he asked V32 to get the nurse (V31) so he could report the incident and was told by V32, Go tell the nurse yourself. I ain't dealing with you. You are a racist. R1 stated V32 (CNA) refused to get the nurse for him. R1 stated he got himself out of bed and went to find V31 (Licensed Practical Nurse/LPN). R1 stated that as he was telling V31 what had happened, V32 (CNA) walked around the corner near the nurses' station, where she had been eavesdropping, and showed a video on her phone while saying, You are not going to get me fired. I have it all on video. R1 stated V31 (LPN) also saw the video. R1 stated V32 (CNA) was not allowed to video record him without his permission and that he had not given permission. R1 stated, Why would I want to be on a video as a paraplegic? That would be embarrassing.On 6/5/26 at 11:00 AM, V32 (CNA) stated that other staff had pre-warned her about R1 being a racist and only allowing certain staff to care for him. V32 stated she was told by other staff that R1 didn't like (African Americans). V32 stated she is Black and sometimes has to deal with racial comments from residents. V32 stated she was assigned to R1 on the night of 5/30/26 into the morning of 5/31/26. V32 stated R1 put on his call light on 5/30/26 and, when she entered his room, he told her to get the f*** out (expletive). V32 stated that when she arrived on the evening of 5/31/26, she was upset about being assigned to R1 due to his comments from the previous evening. V32 stated R1 came out of his room and asked for V31 (LPN). V32 stated R1 was yelling at her and saying she was not doing her job because she would not move R22. V32 stated R22 had gotten up early on the morning of 6/1/26 because R22 was on the get up list. V32 stated R22 was sitting at a table by the nurses' station and was banging the table against the wall adjacent to R1's closet. V32 stated R1 told V31 (LPN) that V32 had been rude as f*** (expletive) to him. V32 stated she did tell R1 that she had audio and video of his behavior to prove she had not done anything wrong. However, V32 stated she only said this to make R1 think he could not get her fired and that she had not actually recorded him. V32 stated R1 said he would call the State Agency regarding her conduct. V32 stated she was afraid she would lose her CNA certification, which is why she said she had recorded R1.On 6/5/26 at 11:35 AM, V1 (Administrator) stated V32 (CNA) did not act appropriately toward R1. V1 stated R1 can be difficult, but staff are trained to respond appropriately and assist residents professionally. V1 stated V32 would not be returning to the facility.2. R3's Minimum Data Set (MDS), dated [DATE], documents R3 as cognitively intact. This same MDS documents that R3 requires supervision with toileting, personal hygiene, and transfers.On (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
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/29/26 at 9:40 AM, R3 stated she was embarrassed and shocked by how she was treated by staff on the morning of 5/11/26. R3 stated she has a normal morning routine of performing daily hygiene, using the bathroom, exercising for 10-15 minutes, and weighing herself before going to breakfast. R3 stated that due to her size, she has difficulty cleansing herself after using the bathroom. R3 stated she asked for assistance that morning and was told by V15 (CNA) that V15 was not supposed to help her. R3 stated, V15 told me I could do everything on my own and she did not have to help me. R3 stated she cleaned herself as best she could but could still smell feces after using the bathroom. R3 stated she then asked V15 to push her wheelchair to the scale because she was running behind after being required to complete her own perineal care.R3 stated V15 began pushing her into the hallway when V14 (LPN) stopped them and stated that R3 could push herself to the scale and needs the exercise. R3 stated she was so pi***d off by the way she had been treated by V15 and V14 that she asked to go outside to cool off. R3 stated, All they (staff) have to do is help me cleanse myself and give me a lift when I am in a hurry. I had to eat a cold breakfast that morning because they made me do everything myself. Why am I even here if I can do everything myself? I am here because I need the help.On 6/2/26 at 10:55 AM, V14 (LPN) stated she was passing medications in the hallway when she saw V15 (CNA) pushing R3 toward the scale to be weighed. V14 stated she stopped V15 and reminded R3 that she needed to push herself to the scale. V14 stated she was unaware of any previous conversations between V15 and R3. V14 stated R3 mentioned needing assistance, but V14 believed R3 was capable of pushing herself and should do so. V14 stated V15 then left R3 sitting in the hallway. V14 stated she could tell R3 was upset but did not realize the extent of her frustration until later.On 6/3/26 at 2:28 PM, V20 (LPN) stated R3 requires the assistance of one person with toileting because she is unable to adequately reach her perineal area to ensure cleanliness after toileting.On 6/5/26 at 9:50 AM, V15 (CNA) stated R3 was very upset on the morning of 5/11/26 because she wanted to be pushed to the scale to be weighed. V15 stated R3 is capable of pushing herself and staff encourage her to do so. V15 stated she tries to encourage residents to do as much for themselves as possible. V15 stated she was pushing R3 toward the scale when V14 stopped them and told R3 to push herself. V15 stated R3 then asked to sit outside. V15 stated she did not realize how upset R3 was at the time but now understands why. V15 stated R3 had also requested assistance with perineal care that same morning. V15 stated she had previously been instructed to have R3 complete her own perineal care to increase independence. V15 stated she told R3 to wash herself up after using the bathroom. V15 stated she did not intend to hurt R3's feelings and that, in the future, she would assist R3 with whatever she needed.On 6/5/26 at 11:40 AM, V2 (Director of Nursing/DON) stated staff had previously been educated on providing R3 assistance with perineal care and transportation assistance to and from wherever R3 wanted to go. V2 stated R3 is cognitively intact and should be provided assistance whenever she requests it.3.R4's Minimum Data Set (MDS), dated [DATE], documents R4 as cognitively intact.R9's MDS dated [DATE], documents R9 as cognitively intact.R10's MDS dated [DATE], documents R10 as cognitively intact.R11's MDS dated [DATE], documents R11 as cognitively intact.On 5/28/26 at 9:45 AM, V4 (CNA) stated that on 5/25/26 she was preparing to pass breakfast trays in the main dining room of the behavioral unit. V4 stated V5 (Assistant Dietary Manager/Cook) approached her while she was standing in the center hallway connected to the dining room, in front of the public restrooms. V4 stated V5 confronted her in an intimidating manner and told her to move the large coffee carafe from the resident dining room table. V4 stated she asked V5 to educate whoever had placed the coffee dispenser on the table not to do it again and that she would move it after using the restroom. V4 stated V5 then yelled, Aren't you a f****** (expletive) CNA?! and You are not that f****** (expletive) busy! V4 stated V5 appeared very angry while yelling profanities at her. V4 stated V5 continued berating her and using profanity for several minutes in front of residents. V4 stated the dining room was full of residents who would have heard the profanity.On 5/28/26 at 11:55 AM, R9 stated he witnessed V4 (CNA) and V5 (Assistant Dietary Manager/Cook) in a screaming match. R9 stated he and R4 were sitting at their usual dining room table after breakfast (continued on next page)

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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 - Some	when V5 approached V4 and began yelling. R9 stated he did not know what they were arguing about but did not care for it and believed it upset R4. R9 stated he and R4 waited until both employees left the area before returning to their rooms because they would have had to walk through the area where the argument occurred.On 5/28/26 at 12:00 PM, R4 stated she heard two staff members (V4 CNA and V5 Assistant Dietary Manager/Cook) arguing after breakfast. R4 stated she and R9 were sitting at their usual table near the main entrance to the dining room on the behavioral unit. R4 stated she did not understand why people do not treat one another with respect. R4 stated it upsets her when there is arguing and bickering.On 5/28/26 at 12:30 PM, V7 (LPN) stated she clearly remembered the day (5/25/26) when V4 (CNA) and V5 (Assistant Dietary Manager/Cook) were arguing. V7 stated V4 was standing in front of the restroom and V5 was at the edge of the dining room hallway, while V7 (LPN) was standing at her medication cart between them. V7 stated V5 asked V4 to move the commercial-sized coffee pot sitting on a resident dining room table where R11 was seated. V4 responded that she would move it after using the restroom and asked V5 to educate whoever left the coffee pot on the table not to do so again because someone could get hurt. V7 stated V4's response angered V5, and they both began yelling. V7 (LPN) stated residents were present and would have heard the shouting match. V7 stated V5 worked in the kitchen and could have simply taken the coffee pot back to the kitchen. V7 stated the tone and volume used by both employees were disruptive to residents. V7 stated, It could have been avoided if (V5) would have just done his job, but he likes to tell others what to do.On 5/28/26 at 1:00 PM, V13 (Floor Care Technician) stated he was present when V4 (CNA) and V5 (Assistant Dietary Manager/Cook) were arguing. V13 stated he could hear both employees yelling from across the dining room while residents were present. V13 stated the argument occurred at approximately 7:15 AM on 5/25/26 as residents were finishing breakfast. V13 stated he had placed the commercial-sized coffee pot on the dining room table because it was in his way and that the pot was mostly empty. V13 stated if he had known it would lead to such a significant argument between V4 CNA and V5 Cook, he would have simply taken the coffee pot back to the kitchen.On 5/28/26 at 2:30 PM, R11 was observed sitting in her wheelchair in her room. R11 stated she heard two employees (V4 and V5) yelling at each other. R11 stated she does not like conflict and did not like having to hear the yelling.On 5/28/26 at 2:50 PM, R10 was observed sitting on the side of her bed. R10 stated she remembered two staff members (V4 and V5) yelling at each other. R10 stated the yelling was uncalled for and that she did not like it. R10 stated she prefers a quiet environment because excessive noise gives her headaches.On 6/2/26 at 9:00 AM, V5 (Assistant Dietary Manager/Cook) stated he was walking out of the kitchen on 5/25/26 carrying garbage through the dining room to take it to the dumpster outside the facility. V5 stated he saw one of the large industrial-sized coffee pots from the break room sitting on a table where R11 was seated. V5 stated he asked V4 to move the coffee pot so R11 would not get hurt. V5 stated V4 responded by yelling, You mother f****** a****** (expletives). V5 stated he did not say anything else other than asking her to move the coffee pot. V5 stated V4 told him that V13 (Floor Care Technician) had placed the coffee pot on the table and that he should ask V13 to move it. V5 stated R11 heard what V4 said. V5 stated R10 was in the dining room and asked whether V4 was trash talking him. V5 stated he did not move the coffee pot because he was taking out the garbage and did not understand why V4 could not move it herself. V5 stated he then reported the incident to V9 (Housekeeping Supervisor).On 6/3/26 at 3:15 PM, V1 (Administrator) stated she had been informed that V4 (CNA) yelled and used profanity toward V5 (Assistant Dietary Manager/Cook) in front of residents but was unaware that V5 had also yelled and used profanity toward V4. V1 stated employees should not engage in verbal altercations in front of residents. V1 stated residents should be able to eat their meals in peace without staff yelling at one another.The facility policy, dated 2021, documents that residents have the right to be treated with dignity, respect, and kindness.

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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 ensure a clean, homelike environment for five (R2, R16, R23, R24, R25) residents and failed to maintain clean resident community areas out of five residents reviewed for physical environment in a sample list of 25 residents. Findings include: 1. On 6/4/26 at 10:10 AM, observation of the 100 Hall shower room was conducted. The room was dry with no obvious odor. A toilet seat riser was stored on a rack against the back wall. The riser had visible long human hair and red/brown staining. The small shower chair had visible brown material spread on the back of the seat opening. The chair's PVC backrest was broken and cracked, with the mesh support torn. The trash can was approximately three-fourths full of soiled incontinence briefs, with additional trash on the floor next to the trash can. A dehumidifier was plugged into the wall near the sink. On 6/4/26 at 10:45 AM, V28 (Housekeeper) stated housekeeping performs a deep cleaning of the shower room every morning, which includes cleaning the shower room, sink, toilet, shower walls and floor, shower chairs, removing trash, sweeping, and mopping. V28 stated there is a housekeeper assigned to each hall seven days per week. On 6/4/26 at 12:05 PM, a second observation of the 100 Hall shower room was conducted. There was no change from the initial observation. Trash remained in the can and on the floor. The broken shower chair with visible brown material on the seat remained in use. On 6/4/26 at 12:10 PM, V26 (Certified Nursing Assistant/CNA) in the 100 Hall shower room, stated housekeeping cleans the shower room every morning and empties the dehumidifier. V26 stated CNAs clean bodily fluids. V26 stated, We use disinfectant to clean the chair in between each resident, then at the end of the day we do the walls and floor. When asked whether shower chairs are cleaned before a resident is placed in them, V26 stated, If I don't know if it's clean, I'll clean it before I use it. Like this one, while pointing to the soiled, broken shower chair, I'd clean before I put someone in it. Yeah, it's obviously dirty. V26 stated CNAs submit maintenance work orders for broken equipment. V26 stated, I'll put in an order for this. V26 further stated all residents on the hall use this shower room. On 6/4/26 at 1:15 PM, observation of the 100 Hall shower room was conducted. The room remained unchanged. Trash continued to be present in the can and on the floor. The broken, soiled shower chair remained in the shower room. The disinfectant bottle used in the shower room was empty. The manufacturer's directions for use state: Spray area from 6 to 8 inches away until visibly wet. Allow disinfectant to remain on the surface for two minutes, then wipe off with a clean paper towel or cloth. These directions apply to both hard and soft surfaces. On 6/4/26 at 1:15 PM, V26 (CNA) stated housekeeping maintains the disinfectant supply and staff request refills from housekeeping. When asked whether the disinfectant requires a contact time and to describe her cleaning process, V26 stated, I spray the disinfectant, wipe it down, and then rinse it off with the shower head. I don't wait any time before I wipe it down. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/5/26 at 9:40 AM, observation of the 100 Hall shower room was conducted. The broken shower chair remained in the shower room. The chair was clean with no visible debris or staining. On 6/5/26 at 1:10 PM, R23 stated, If I knew I was going to sit in a dirty chair, I'd be upset. On 6/5/26 at 1:15 PM, R24 stated, It would make me mad if I saw feces in there. R23's Minimum Data Set (MDS) documents a Brief Interview for Mental Status (BIMS) score of 15. R23 receives a shower twice weekly. R24's MDS documents a BIMS score of 15 and that R24 also receives showers twice weekly. The disinfectant directions state to spray the area from 6 to 8 inches away until visibly wet and allow the disinfectant to remain on the surface for two minutes before wiping with a clean paper towel or cloth. These directions apply to both hard and soft surfaces. Review of the facility's Housekeeper Duties document showed shower rooms are to be cleaned daily. The Illinois Long-Term Care Ombudsman Program booklet titled Residents' Rights for People in Long-Term Care Facilities, revised 11/02/18, documents, Your facility must be safe, clean, comfortable, and homelike. 2. On 6/4/26 at 10:10 AM, observation of R2's bathroom revealed the floor was missing any type of finished flooring surface, such as tile. The bathroom floor consisted of exposed concrete with multiple brown rings and stains present. The bathroom had a strong urine odor. The bottom corner of the bathroom door contained an approximately 4-inch-tall by 2-inch-wide hole. On 6/4/26 at 10:15 AM, R2 stated he would like to live in a room that isn't a danger zone. R2 stated his previous room was not in poor condition and that he expected his new room to be put together. R2 stated he should not have to live in a rat trap roach motel. 3. On 6/3/26 at 1:20 PM, observation of R16's room revealed the wall behind the head of the bed contained an approximately 3-foot-long by 2-foot-wide area with dozens of scrape marks approximately 1 foot in length, exposing the drywall underneath. The wall was painted dark brown, and the scrape marks exposed the white drywall beneath the paint. On 6/3/26 at 1:25 PM, R16 stated she likes to live in a room that looks presentable. R16 stated the damaged wall had been in that condition forever and that she had asked the facility to repaint it. R16 stated that instead of repairing the wall, staff moved her bed to help conceal the damaged area. R16 stated she would like to have the wall repaired. 4. On 6/3/26 at 2:45 PM, observation of R25's room revealed approximately one-third of the paint was missing from the walls. The room was painted dark brown, and the missing paint exposed the white drywall underneath. The condition was readily visible to staff, residents, and visitors. On 6/3/26 at 2:47 PM, R25 stated he would like the wall repainted the same color. 5. Observations made throughout the survey of resident common areas revealed the following: On 6/3/26 at 2:30 PM, the baseboard at the total-body mechanical lift station on the 100 Hall (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	contained broken tile measuring approximately 4 inches by 4 inches. This area was located next to the nurses' station in a resident common area and was clearly visible to residents, staff, and visitors. On 6/3/26 at 2:35 PM, the baseboard in the behavioral unit dining room was curled outward for approximately 3 feet, creating a potential hazard and exposing the concrete underneath. The dining room walls contained dozens of liquid splatters and drips. The walls and floor showed visible buildup of grime and dirt. Three dining room tables were stained with a red substance. The floor beneath the tables was also stained with a red substance. Multiple deep scuff marks were present on the floor, exposing the underlying material of the floor tiles. On 6/3/26 at 2:40 PM, the floor in front of V12 (Psychiatric Rehabilitation Services Director/PRSD)'s office, which is also a resident common area, contained multiple deep scuff marks. The surface layer of the floor tiles had been worn away in several locations. Residents were observed walking through this area. On 6/4/26 at 10:20 AM, the resident common area located between the resident halls on the behavioral health unit contained dozens of dark brown scuff marks, several inches in diameter, that had worn through the surface of the tile flooring. On 6/4/26 at 3:00 PM, V34 (Maintenance Director) stated the facility is aware that portions of the resident areas require repairs, painting, replacement flooring, and overall deep cleaning. V34 stated the facility has developed a plan to address the issues but had not yet begun the work. On 6/5/26 at 1:20 PM, V1 (Administrator) stated the facility has plans to repair and/or replace many resident areas, particularly within the behavioral unit. V1 stated all residents should be provided with a clean and homelike environment.

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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 the residents' right to be free from verbal abuse by another resident (R2) for two residents (R1, R19) out of seven residents reviewed for abuse in a sample list of 25 residents. Findings include:1. R1's Electronic Medical Record (EMR) documents medical diagnoses of Paraplegia, Traumatic Brain Injury, Injury at the T7-T10 Level of the Thoracic Spinal Cord, Adjustment Disorder with Anxiety, Opioid Dependence, and Chronic Pain.R1's Minimum Data Set (MDS), dated [DATE], documents R1 as cognitively intact. This same MDS documents that R1 self-propels a wheelchair for mobility.R2's (EMR) documents medical diagnoses of Morbid Obesity, Tobacco Use, Generalized Anxiety Disorder, Acquired Bilateral Above-the-Knee Amputations, and Major Depressive Disorder in Partial Remission.R2's (MDS), dated [DATE], documents R2 as cognitively intact. This same MDS documents that R2 self-propels in a motorized wheelchair.R1 and R2's shared report to the State Agency, dated 5/24/26, documents that the investigation findings supported that R2 was verbally aggressive, disruptive, and displayed inappropriate behavior toward R1 on 5/23/26. This same report documents that multiple witness statements corroborated R2 yelling, using profanity, making racial slurs, and making threatening comments.On 5/30/26 at 11:10 AM, R1 stated R2 was at it again and that the facility had sent R2 to the hospital. R1 stated R2 yelled and cursed at him while they were sharing a smoking break. R1 stated R2 was now back on the behavioral unit. R1 stated that as long as R2 stayed on the behavioral unit, he was happy. R1 stated, I am tired of (R2's) s*** (expletive). I am glad he is back there. I got what I wanted. Now I won't have to deal with him.On 5/30/26 at 10:15 AM, R2 stated he was outside smoking on the evening of 5/23/26. R2 stated R13 and R15 were already outside when he arrived. R2 stated R1 then came outside to the smoking area and intentionally pushed the metal awning while walking by, causing it to make a loud twang noise, which R2 stated he does not like. R2 stated he could not prove it, but that R1 does things like that all the time to instigate him. R2 stated he called R1 names, causing R1 to go back inside. R2 stated R1 later returned and struck the metal awning again while smiling. R2 stated he was calling R1 bad names when V16 (LPN) came outside and told everyone to calm down. R2 stated that by then he was so angry that he continued calling R1 names such as little b**** (expletive), dirty b**** (expletive), and cry baby little p**** (expletive). R2 stated, Everything was yelling and verbal. Nobody hit each other.On 6/2/26 at 2:00 PM, V16 (Licensed Practical Nurse/LPN) stated she was R1 and R2's nurse on the evening of 5/23/26. V16 stated R2 had gone outside to smoke and then R1 also went outside to smoke. V16 stated R1 later came inside and reported that R2 was cursing at him. V16 stated that when she went to the smoking area, R1, R2, R13, and R15 were outside. V16 stated R2 was yelling at R1, calling him names, and also calling V16 offensive names. V16 stated R2 yelled at R1, you little b**** (expletive), you dirty b**** (expletive), and cry baby little p**** (expletive). V16 stated that when she attempted to calm R2, he began yelling racial slurs and profanities at her. V16 stated R2 called her a b**** and a c*** (expletives). V16 stated R1 did not help the situation because he was yelling, I will call the State (State Agency) on all of you! V16 stated R1 and R2 are both cognitively intact residents who do not like one another. V16 stated staff are expected to redirect R1 and/or R2 from smoking at the same time. V16 stated she had redirected them in the past but did not do so on 5/23/26 because she was unaware they were outside together.On 6/3/26 at 9:45 AM, R15 stated he was outside near the couches while R2 was under the awning. R15 stated R2 loudly said, (R1) is doing that s*** (expletive) just to piss me off. R15 stated he got tired of hearing it and went back inside.On 6/3/26 at 10:00 AM, R13 stated she was outside smoking when R2 came outside on 5/23/26. R13 stated R2 was not causing any problems until R1 also came outside. R13 stated R1 bumped the metal awning and R2 began yelling obscenities at him. R13 stated R2 called R1 a little b**** (expletive) and other foul names. R13 stated, I get so tired of these two (R1, R2). They are (continued on next page)

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	145584	A. Building B. Wing	06/05/2026

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	always yelling at each other. I just want to smoke and chill. I went back inside because I was tired of hearing them go at it again. It stressed me so much I called my family and asked them to come get me for a home visit.On 6/3/26 at 1:00 PM, V1 (Administrator) stated R1 and R2 were involved in a verbal altercation while smoking outside on 5/23/26. V1 stated R1 came inside to get V16 (LPN). V1 stated V16 went outside and asked all other residents to return inside the facility. V1 stated V16 then contacted V1, who instructed her to call the police regarding R2. V1 stated R1 instigates R2 but is smart enough to stay under the radar. V1 stated the facility is aware that R2 responds to R1's prodding, but staff have been unable to prove it. V1 stated R2 did yell and carry on toward R1 on 5/23/26 and that the facility must acknowledge R1's right to be free from verbal aggression, while also recognizing that R1 often starts it. V1 stated staff are expected to monitor both residents every 15 minutes. V1 stated staff are also expected to redirect R1 and/or R2 if one resident wishes to smoke while the other resident is already outside. V1 stated R1 and R2 are not supposed to have shared smoking times.2. R19's (MDS), dated [DATE], documents R19 as cognitively intact.R2's (EMR) documents medical diagnoses of Morbid Obesity, Tobacco Use, Generalized Anxiety Disorder, Acquired Bilateral Above-the-Knee Amputations, and Major Depressive Disorder in Partial Remission.R2's (MDS), dated [DATE], documents R2 as cognitively intact. This same MDS documents that R2 self-propels in a motorized wheelchair.R2's Nurse Progress Note, dated 6/3/26 at 3:30 PM, documents that R2 and other residents were on a smoke break when R2 began cursing and taunting other residents to fight with him. This same note documents that R2 stated, Come on. Bring it on. This chair isn't stopping me, and I will run you over with this chair.On 6/3/26 at 4:00 PM, V27 (Certified Nursing Assistant/CNA), V17 (Registered Nurse/RN), and V12 (Psychiatric Rehabilitation Services Director/PRSD) stated R2 was outside smoking when he became agitated because the facility door would not open properly. V27 stated she was outside with the residents during the 3:00 PM smoke break on 6/3/26 and that the door to the smoking area became stuck. V27 stated she handed R19 the lighter so he could attempt to open the door while she assisted. V17 (RN) stated she was pushing on the door from the inside while V27 (CNA) pulled from the outside. V27 stated the door eventually became unstuck. During that time, R19 lit his own cigarette and then lit another resident's cigarette. V27 stated R2 began yelling profanities at R19. V27 stated R2 yelled that R19 should not be lighting other residents' cigarettes and complained that R2 had been skipped. V17 (RN) stated she heard R2 yelling and cursing at R19. V17 stated R2 called R19 a little b**** (expletive) and a stupid b**** (expletive). V17 stated R19 responded by telling R2 he was going to kick his a** (expletive) and that R2 was going to get it. V27 stated R19 told R2 he needed to stay out of it, and R2 responded, Come over here and I'll beat your a** (expletive). V27 stated R19 then told R2 he was going to get him if R2 did not stop. V27 stated the two residents continued yelling at one another. V17 (RN) stated that if R2 comes at me, then R19 would swing back.On 6/4/26 at 1:10 PM, R19 stated he was outside for a smoke break on 6/3/26 when there was a problem with the door leading back into the building. R19 stated V17 (RN) and V27 (CNA) worked on the door and fixed it within a few minutes. R19 stated that while V27 (CNA) was working on the door, she handed him the lighter and instructed him to begin lighting residents' cigarettes. R19 stated R2 became upset because his cigarette was not lit first and began yelling at him. R19 stated R2 called him all kinds of names. R19 stated R2 yelled, you little b**** (expletive) and you are a stupid b**** (expletive). R19 stated he does not like being called names and responded by yelling that he would kick R2's a** (expletive). R19 stated V27 then instructed everyone to calm down and that was the end of it.On 6/4/26 at 3:10 PM, V1 (Administrator) stated R2 yelled profanities at R19 during a scheduled smoke break on the behavioral unit. V1 stated it is difficult to prevent verbal abuse because it is often impossible to predict when it will occur. V1 stated all residents have the right to be free from abuse and that the facility is responsible for maintaining resident safety.The facility policy titled Resident Rights and Abuse Prevention Policy and Procedure Manual, revised April 2021, documents that residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The policy further documents that (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	this right includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraints not required to treat the resident's symptoms.The policy defines verbal abuse as the use of verbal, written, or gestured communication, or sounds, directed toward residents within hearing distance, regardless of age, ability to comprehend, or disability.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to immediately report verbal abuse to the Abuse Coordinator for one (R19) resident by another resident (R2) out of seven residents reviewed for abuse in a sample list of 25 residents.Findings include:R19's Minimum Data Set (MDS), dated [DATE], documents R19 as cognitively intact.R2's (MDS) dated [DATE], documents R2 as cognitively intact.R2 and R19's shared report to the State Agency, dated 6/4/26, documents that R2 yelled profanities at R19 during a shared smoke break at 3:00 PM on 6/3/26.On 6/3/26 at 4:00 PM, V27 (Certified Nursing Assistant/CNA), V17 (Registered Nurse/RN), and V12 (Psychiatric Rehabilitation Services Director/PRSD) stated that R2 yelled and used profanity toward R19 while they were on a smoke break.On 6/3/26 at 4:05 PM, V17 (RN) stated she heard R2 yelling and using profanity toward R19. V17 stated R2 called R19 a little b**** (expletive) and a stupid b**** (expletive). V17 stated there was no need to report the incident to V1 (Administrator/Abuse Coordinator) because neither R2 nor R19 became physically aggressive toward one another.On 6/3/26 at 4:30 PM, V1 stated she was unaware that a resident-to-resident incident had occurred on the behavioral unit. V1 stated staff should have reported the incident immediately.The facility policy titled Resident Rights and Abuse Prevention Policy and Procedure Manual, revised April 2021, documents that if resident abuse, neglect, exploitation, misappropriation of resident property, or an injury of unknown source is suspected, the suspicion must be reported immediately to the Administrator and to other officials in accordance with State law.The policy further documents that occurrences of such incidents are to be promptly reported to the nurse supervisor, Director of Nursing Services, and Administrator.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to accurately document behaviors for three (R1, R2, R6) residents out of three residents reviewed for behavioral health in a sample list of 25 residents.Findings include: 1.R1's Electronic Medical Record (EMR) documents medical diagnoses as Paraplegia, Traumatic Brain Injury, Injury at T7-T10 level of Thoracic Spinal Cord, Adjustment Disorder with Anxiety, Opioid Dependence and Chronic Pain. R1's Minimum Data Set (MDS) dated [DATE] documents R1 as cognitively intact. This same MDS documents R1 self propels a wheelchair for mobility.R1 and R2's shared report to the State Agency dated 5/24/26 documents the investigation findings support R2 was verbally aggressive, disruptive and showing inappropriate behavior towards R1 outside at the smoking patio. This same report documents the incident occurred on 5/23/26 at 7:00 PM. R1's Behavioral Tracking Sheet dated May 1-31, 2026 does not document any yelling, verbal behaviors directed at others, accusing of others, cursing at others and/or screaming at others. This same behavioral tracking documents No behaviors observed. R1's Resident Monitoring form dated 5/23/26 documents R1 was in his room in bed from 4:00 PM through 12:00 AM 5/24/26.On 6/5/26 at 12:10 PM V1 (Administrator) stated she is aware of the issue with documentation and is educating staff again to ensure not only behaviors but all necessary documentation is completed by the end of each shift. 2.R2's Electronic Medical Record (EMR) documents medical diagnoses as Morbid Obesity, tobacco use, Generalized Anxiety Disorder, Acquired above the knee bilateral amputations and Major Depressive Disorder in partial remission. R2's (MDS) dated [DATE] documents R2 as cognitively intact. This same MDS documents R2 self propels in a motorized wheelchair. R2's Behavioral Tracking Sheet dated May 1-31, 2026 documents R2 was agitated on 5/2, 5/6, and 5/8. This same form does not document any yelling, verbal behaviors directed at others, accusing of others, cursing at others and/or screaming at others for the remainder of the month. This same behavioral tracking documents No behaviors observed for the remainder of the month. R2's Nurse Progress Notes document R2 yelling at staff on 5/12 and 5/24. R2's Nurse Progress Notes do not document any other behaviors for R2. On 6/5/26 at 12:05 PM V2 (Director of Nurses/DON) stated behavior tracking must be completed every shift to give an accurate depiction of the resident behavioral status. V2 stated V37 (Psychiatric Nurse Practitioner/NP) can better determine whether or not to make changes in the residents medication regime or implement new non-pharmacological interventions. 3.R6's Electronic Medical Record (EMR) documents medical diagnoses as Dementia, Altered Mental Status, Diabetes Mellitus Type II and Respiratory Conditions due to unspecified external agent. R6's (MDS) dated [DATE] documents R6 as cognitively intact. R6's Behavioral Tracking Sheet dated May 1-31, 2026 does not document any yelling, verbal behaviors directed at others, accusing of others, cursing at others and/or screaming at others. This same behavioral tracking documents No behaviors observed. R6's Nurse Progress Notes dated 5/16/26 at 9:20 PM document R6 was involved in a verbal altercation on 5/16/26 at 6:20 PM. On 5/28/26 at 12:10 PM R9 stated R9 and R4 both were sitting in the common area when R6 yelled at V12 (Psychiatric Rehabilitation Services Director/PRSD). R9 stated R6 was ?aggressive, mean and out of control' towards V12. R9 stated (R6) is the only other resident I am afraid of because he gets so violent so quick for no reason. I do everything I can to avoid him. But I was scared for (V12) that day because you never know what (R6) will do. R9 stated he clearly heard R6 yell ?Go f*** yourself' to V12. On 5/28/26 at 12:40 PM V12 (PRSD) stated on 5/25/26 R8 loaned R6 $5 so that R6 could get R8 some chips. V12 stated this is against the rules in the locked unit so she asked R6 to return the money to R8. V12 stated that is when R6 became verbally aggressive toward V12. V12 stated R6 was yelling profanities at her in front of other residents. V12 stated R4 and R9 were witnesses to R6's verbal outburst. V12 stated it is important to document all abnormal behaviors so that the provider can (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	determine if there needs to be a change in medications or interventions to help the resident behave appropriately. V12 stated she is aware the documentation is lacking and is working on educating staff to complete the behavior tracking every day.