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	01/24/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 41970 Based on observation, interview and record review the facility failed to report injuries of unknown origin to the State Agency for one (R22) out of one resident reviewed for abuse in a sample list of 33 residents. Findings include: R22's undated Face Sheet documents medical diagnoses of Cerebral Palsy, Mild Intellectual Disabilities, Schizoaffective Disorder, Bilateral Hearing Loss, Legal Blindness, Need for Assistance with Personal Care, Muscle Weakness and Dysphagia. R22's Minimum Data Set (MDS) dated [DATE] documents R22 as severely cognitively impaired. This same MDS documents R22 is dependent on staff for toileting, oral hygiene, personal hygiene and requires maximum assistance for bathing and transfers. R22's Care plan intervention dated 10/17/23 instructs staff to follow facility protocols for treatment of injury. This same care plan documents an intervention dated 2/23/24 that instructs staff to monitor behavior episodes and attempt to determine underlying cause. Document behavior and potential causes. R22's Shower /Abnormal Skin Report dated 12/17/24 documents no new skin findings. R22's Shower/Abnormal Skin Report dated 12/19/24 documents R22 has bruises on her legs, arm and under eye. R22's Nurse Progress Note dated 12/20/24 at 8:50 AM documents R22 appears to have an injury that was unwitnessed or is of unknown origin. Location of the event is unknown. V1 (Administrator) was notified on 12/20/24 at 7:00 AM. R22's Nurse Progress Note dated 12/20/24 at 9:10 AM documents This nurse was notified by V6 (Certified Nurse Assistant/CNA) that R22 had a black eye on her Right eye. Upon skin assessment this nurse noted more bruising to body (see aims). Witness statements gathered due to unknown origin of bruising, neurological assessment initiated and requested X-Ray to Right Lower Leg (RLL) from provider. (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: 145584	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R22's AIMS assessment dated [DATE] documents R22 was found to have Right Buttock bruising measuring 4.0 centimeters (cm) long by 2.0 cm wide, Outer Right lower Thigh bruise measuring 3.0 cm long by 2.0 cm wide, Right Hip bruise measuring 5.0 cm long by 2.0 cm wide, Right Lower Inner leg 15.0 cm long by 9.0 cm wide, Left Trochanter 3.0 cm long by 2.0 cm wide, Right Lower Leg Rear bruise measuring 12.0 cm long by 10.0 cm wide and Right and Left eye bruising with no measurements documented. V8 (CNA) witness statement dated 12/20/24 documents V8 worked on 12/18/24 when R22 did not have any bruising on her body. The facility was unable to provide documentation of behavior tracking sheets for R22 for the months of December 2024 and January 2025. The facility fall log dated December 2024 and January 2025 does not document any falls for R22. The facility Weekly Skin Log dated December 2024 and January 2025 does not document any skin injuries for R22. On 1/21/25 at 11:30 AM R22 was sitting at her dining room table feeding herself lunch meal. R22 was not displaying any behaviors. On 1/22/25 at 2:00 PM R22 was laying in her bed under covers. R22 yelled out when her room door opened. On 1/23/25 at 3:00 PM R22 was laying in her bed in low position under her covers. No obvious hazards in R22's room. R22 had pictures on her walls that would be out of her reach. R22's wheelchair was sitting outside her room with padding on the front leg bars. On 1/23/25 at 1:00 PM V6 (CNA) stated V6 was assigned to R22 on 12/19/24 when V6 noticed R22 had multiple bruises on various parts of her body including a Left eye bruise. V6 stated when V6 returned to work on 12/20/24 R22 had a Right eye bruise in addition to all the other bruises noted. V6 stated We (staff) were all trying to figure out how (R22) could have gotten so many bruises all at once. We talked about her maybe hurting herself, but she doesn't hit herself or anything. Sometimes she self-transfers but those bruises were not there before 12/19/24. I let the nurse (V4) Licensed Practical Nurse (LPN) know about it and I think she called the doctor. I am not sure about that, but I know no one could figure out how (R22) got all those bruises. On 1/23/25 at 2:15 PM V4 (Licensed Practical Nurse/LPN) showed a picture of R22's bruised eyes. V4 stated the picture is used for an application used to notify the Physician. V4 stated the staff can text or send pictures of residents to the provider due to the app is secure and only used for resident information and is considered a part of the resident medical record. R22's Left and Right eyes both showed dark purple and red bruising on upper eyelids, lower eyelids and at inner and outer corners of both eyes. R22's nose, brow bones, nor cheek bones were not bruised. V4 stated V6 (CNA) notified her on 12/20/24 that R22's eyes were bruised. V4 stated a full body check was completed and there were multiple other new bruises noted. V4 stated R22's bruising was dark purple and red indicating the bruises were new/recently obtained. V4 stated V1 (Administrator) was notified of the bruising on 12/20/24. V4 stated the staff worked together to try to figure out a cause of all the bruises. V4 stated the staff reported that R22 had behaviors a week ago but nothing just prior to the bruising noted. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/24/25 at 9:00 AM V1 (Administrator) stated R22 is known to have behaviors of throwing herself out of her wheelchair. V1 stated there is no direct cause of R22's bruising between 12/18/24 when the facility documented there were no findings with R22's skin and 12/20/24 when R22 was noted to have multiple bruises including two black eyes. V1 confirmed R22's bruising would be considered injuries of unknown origin. V1 stated she did not report R22's bruising to the State Agency. The facility policy titled Abuse Prevention Program dated 2/2021 documents the facility must ensure that all alleged violations involving mistreatment, exploitation, neglect or abuse, including injuries of unknown source, misappropriation of resident property, and reasonable suspicion of a crime, are reported immediately to the Administrator of the facility and to other officials in accordance with State law through established procedures. Within five working days after the report of the occurrence a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation, will be sent to the (state surveying agency.)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 37813 Based on interview and record review the facility failed to obtain a level II PASARR (Preadmission Screening and Record Review) for one resident (R31) of four residents reviewed for PASARR screenings identified as not having a diagnosis of serious mental Illness by the Level I PASARR but later was diagnosed with a serious mental illness in a sample of 33. Findings Include: R31's Care Plan dated 12/17/24 includes the following diagnoses: Psychotic Disorder, Cerebral Infarction with Dominant Right sided Hemiparesis/Hemiplegia, Anxiety, Major Depression, Dysphagia, Muscle Weakness, and Reduced Mobility. R31's Level I PASARR obtained prior to R31's admission on 11/6/2015 documents no under the category History of Severe Mental Illness. However, the diagnoses Psychotic Disorder with Hallucinations was added to R31's diagnoses list on 7/24/21. The facility did not provide documentation a Level II PASARR was obtained. On 1/24/25 at 10:00 AM V14 (Admissions and Marketing Coordinator) stated We do not have a Level II PASARR for (R31). I have arranged to have one completed as soon as the screener is available. On 1/24/25 at 10:30AM V1 (Administrator) verified (V14) is the staff member accountable for PASARR screenings. V1 indicated the facility does not have a specific policy for PASARR screening but follows the regulations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145584	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 37813 Based on interview and record review the facility failed to obtain a level II PASARR (Preadmission Screening and Record Review) for one resident (R3) of four residents reviewed for PASARR screenings identified as having a diagnosis of serious mental Illness by the Level I PASARR in a sample of 33. Findings Include: R3's Care Plan reviewed 11/13/24 include the following diagnoses: Schizophrenia, History of Traumatic Brain Injury, and Major Depression. R3's Level I PASARR obtained prior to R3's admission on 9/12/99 documents yes under the category History of Severe Mental Illness. The facility did not provide documentation a Level II PASARR was obtained. On 1/24/25 at 10:00 AM V14 (Admissions and Marketing Coordinator) stated We do not have a Level II PASARR for (R3). I have arranged to have one completed as soon as the screener is available. On 1/24/25 at 10:30AM V1 (Administrator) verified (V14) is the staff member accountable for PASARR screenings. V1 indicated the facility does not have a specific policy for PASARR screening but follows the regulations.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on observation, interview, and record review the facility failed to prevent cross contamination during wound treatment and failed to assess, monitor, obtain treatment orders and implement care plan interventions for pressure sores for one (R75) of three residents reviewed for pressure sore in a sample list of 33 residents. Findings include: R75's undated Face Sheet documents R75 admitted to the facility on [DATE]. This same face sheet documents R75's medical diagnoses as Right Femur Fracture (12/24), Aneurysm of Heart, Chronic Congestive Heart Failure, Atrial Fibrillation, Chronic Kidney Disease, Morbid Obesity, Right Buttock Pressure Ulcer Stage II, Diabetes Mellitus Type II, and Dysuria. R75's Minimum Data Set (MDS) dated [DATE] documents R75 as cognitively intact. This same MDS documents R75 is dependent on staff for assistance with toileting and transfers and requires maximum assistance from staff for bathing, dressing and personal hygiene. R75's Shower/Abnormal Skin Report dated 1/16/25 documents R75's Coccyx was red and bleeding. R75's Medical Record does not document a Skin Evaluation dated 1/16/25 for R75's open Coccyx wound. R75's Medical Record does not document assessment nor treatment of R75's open Coccyx wound nor Left Buttock wound from 1/16/25-1/23/25. R75's Care plan initiated 8/20/24 does not document R75's Left Buttock Stage II Pressure Ulcer nor Coccyx Stage II Pressure Ulcer. R75's Nurse Progress Note dated 1/23/25 at 1:51 PM documents R75's Left Buttock wound measured 0.5 centimeters (cm) long by 0.5 cm wide and R75's Coccyx wound measures 2.0 cm long by 0.5 cm wide. R75's Initial Wound Management Evaluation report dated 1/23/25 documents R75's Left Buttock Stage II Pressure Ulcer and R75's Sacrum Stage II Pressure Ulcer. On 1/23/25 at 12:50 PM V5 (Licensed Practical Nurse/LPN) completed wound care for R75's Left Buttock Stage II Pressure Ulcer and Coccyx Stage II Pressure Ulcer. V5 removed R75's incontinence brief which was fully saturated and malodorous. R75 was in a standing position and stated he was tired of standing so R75 sat in his wheelchair. R75's two open wounds made direct contact with R75's contaminated wheelchair cushion. V5 assisted R75 back to a standing position and did not cleanse R75's wounds prior to applying Hydrocolloid dressings. R75's wheelchair cushion showed a wet spot and area of contamination from feces due to R75 being incontinent when sitting in wheelchair. V5 confirmed the areas on R75's wheelchair cushion were from R75's urinary and fecal incontinence. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/23/25 at 1:20 PM V5 (LPN) stated V5 cross contaminated R75's open wounds by not cleansing the wounds after R75 stood back up. V5 stated cross contaminating R75's wounds could cause infection in the wounds. On 1/23/25 at 2:00 PM V1 (Administrator) stated V1 is overseeing the wound program. V1 stated the nursing staff should try to prevent cross contamination of open wounds. V1 stated the facility nurses should follow the facility policies for wound care and infection control. The facility policy titled Decubitus Care/Pressure Ulcers revised 1/18 documents it is the policy of the facility to ensure a proper treatment program has been instituted and is being closely monitored to promote the healing of any ulcer. The pressure ulcer will be documented on the Treatment Administration Record (TAR) or the Wound Log, upon notification of skin breakdown the Quality Assurance form for Newly Acquired Skin Condition will be completed and forwarded to the Director of Nurses. The pressure ulcer will be assessed and documented on the TAR. Document size, stage, site, depth, drainage, color, odor, and treatment. Documentation of the pressure ulcer should be completed at least once a week.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37813 Failures at this level require more than one Deficient Practice Statement. A. Based on observation, interview, and record review the facility failed to supervise a resident after providing the resident with a hot pureed food. This failure affects one (R31) of six residents reviewed for accidents in the sample of 33. This failure resulted in R31 spilling hot liquid on R31's lap sustaining redness and 3 blistered areas to R31's bilateral lower extremities requiring subsequent treatment which is ongoing. B. Based on observation, interview, and record review the facility failed to remove a tripping hazard to prevent a fall and failed to implement fall interventions and complete a root cause analysis for two residents (R133, R20) of six residents reviewed for accidents in the sample of 33. This failure resulted in R133 sustaining an unwitnessed fall leading to hospitalization for a Subdural Hematoma. C. Based on observation, interview, and record review the facility failed to prevent siderail entrapment for one of six residents (R54) reviewed for accidents in a sample list of 33 residents. Findings Include: a.1.) R31's Care Plan dated 12/17/24 includes the following diagnoses: Psychotic Disorder, Cerebral Infarction with Dominant Right sided Hemiparesis/Hemiplegia, Anxiety, Major Depression. Dysphagia, Muscle Weakness, and Reduced Mobility. R31's Minimum Data Set (MDS) dated [DATE] documents R31 is Severely Cognitively Impaired, has Bilateral Decreased Range of Motion to Lower and Upper Extremities, is Wheelchair Bound, and Totally Dependent on staff for eating. R31's Progress Note dated 1/19/2025 at 2:53 PM documents (R31) spilled beets on lap Administrator, Power of Attorney, Nurse Practitioner on call, and Hospice notified. Administered Morphine for pain and cool compress. Hospice nurse will see (R31) tomorrow. (Physician) ordered Antibiotic Ointment to be applied. On 1/22/25 at 11:00 AM V1 (Administrator) stated We did not initiate an incident investigation for (R31's) burn. I didn't feel like we needed to. There wasn't a serious injury. On 1/23/25 at 12:00PM V7 (Certified Nursing Assistant/CNA) stated I was working on 1/19/25 in the dining room. I was feeding another resident when they brought (R31's) lunch tray out and set it in front of (R31). (R31) is anxious and she will grab at things. The next thing I knew (R31) hit the hot beets in (R31's) lap. I went ahead and fed (R31). (R31) was wearing slacks and a top and I covered the spill. I didn't have any idea those beets were so hot. Then when I got (R31) back to bed 25 minutes or so later and removed (R31's) pants I discovered (R31) had been burned. I got the nurse right away. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 1/23/25 at 12:10 PM V5 (Licensed Practical Nurse/LPN) stated I knew (R31) had spilled the beets in her lap on 12/19/25, but I wasn't aware until (V7) took (R31) to bed and took off (R31's) pants, (R31) had been burned. (R31's) thighs were red and tender and later blisters came up and burst. I notified (V1), the Nurse Practitioner on Call, Hospice, and resident's representative. We got an order for Antibiotic Ointment, and I applied that and cool compresses. On 1/21/25 at 12:00 PM and on 1/22/25 at 11:45 AM R31 was observed sitting at the dining room table with uneaten hot foods in front of (R31). There were no staff visible directly assisting R31. R31 was muttering and moving hands back and forth. On 1/23/25 at 2:00 PM R31 was lying in bed. V5 (LPN) pointed out an open area on R31's left outer thigh appearing as a sloughing blister approximately 1/2 in diameter, another sloughing blister on R31's Left inner thigh approximately 1 in diameter, and another sloughing blister on R31's Right inner thigh approximately 1/2 in diameter with a separate area on R31's right thigh measuring approximately 1/2 in diameter. On 1/23/25 at 12:30 PM V13 (Dietary Manager) stated The beets went out on 1/19/25 at a temperature of 180 degrees Fahrenheit. I had no idea those little insulated bowls keep the temperature so hot. I was wrong and I will not let that happen again. On 1/24/25 at 11:00 AM V1 (Administrator) denied the facility has a policy for incident reporting or investigation. V1 stated now we are making sure (R31) does not have the food in front of (R31) before (R31) is fed. When notified R31 had hot food in front of R31 unsupervised on 1/21/25 and 1/22/25, V1 stated I'll look into that and verified (R31) should not have been unsupervised with hot food in front of (R31). 20892 b. 1.) The facility's investigation report for R133 dated 1/12/25 no time given documents (R133) had an unwitnessed fall in his room. Roommate was not in the room at the time of the fall. (R133) was transferred to emergency room at the local hospital who transferred (R133) to another hospital for care. R133's Physician's Order Sheet (POS) dated January 2025 documents the following diagnoses: Parkinson Disease, Schizophrenia, Depression, Diabetes and Epileptic Seizures. R133 is able to be interviewed and walks with his walker. On 1/21/25 at 11:00 AM R133 stated Yes, I fell in my room, I got up from bed to go to the bathroom and I tripped on the fall mat that was next to my bed. I had to go to the hospital, and they transferred me to another hospital. I came back home on 1/10/25. R133 continue to say My fall mat next to my bed was torn, I had that fall mat for a long time. I have a new fall mat now. On 1/23/25 at 11:30 AM the fall mat which was removed from R133's room was torn on the bottom. The netting on the bottom of the fall mat was ripped from the bottom of the mat and was hanging down off the mat. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The hospital emergency department Radiology Results records dated 1/5/25 document R133 arrived at the Emergency Department on 1/5/25 at 2:05 PM and a CT (computed tomography) Scan without Contrast was completed which documented Left frontoparietal Subdural Hematoma is slightly higher attenuation than previously suggesting interval rebleeding. The emergency documentation dated 1/5/25 documents RN called to NH (nursing home) to notify facility (R133) will need to be transferred to higher level of care facility due to CT results. Hospital records document (R133) transferred to another hospital for care on 1/5/25. The records document the receiving hospital decision was R133 need to have an embolization procedure, which was performed on 1/8/25. Hospital records document Impression after the procedure. Successful intracranial portion of the left middle meningeal artery embolization without immediate procedure complications. The records document R133 was discharged back to the facility on [DATE]. V10 (CNA) stated per phone interview on 1/23/25 at 10:22 AM I was sitting at the nurses desk charting when I heard yelling and I went to check and found (R133) face down on his stomach, hands under his chin and (R133) stated 'I tripped on my mat going to the bathroom.' V10 stated the nurse was notified and came to the room and assessed R133 and stated she was going to call EMS (Emergency Medical Services) for R133 and R133 was taken to the hospital. On 1/23/25 at 1:08 PM V11 (Nurse Practitioner) stated According to my information from the hospital records I have in front of me (R133) received a Subdural Hematoma from the fall. I understand he did not lose consciousness but still needed the embolization procedure to be done. R133's investigation report dated 1/5/25 no time available, documented the root cause analysis for R133's fall was due to frayed safety mat by R133's bed. 2.) R20's Care Plan revised 1/13/25 includes the following diagnoses: Closed Fracture Left Radius, Moyamoya Disease, Age Related Physical Disability, Generalized Anxiety Disorder. R20's Minimum Data Set (MDS) dated [DATE] documents R20 has a history of falls. R20's Care Plan includes a problem first initiated 12/29/23 and continued since then documenting (R20) is unsafe with transfers and often attempts to transfer self. (R20) has had numerous falls related to self-transferring. This Care Plan also states 1/7/2025: Actual Fall: 15-minute checks for safety and positioning. Date Initiated: 01/07/2025. Although 15 Minute checks were check marked as complete in the electronic medical record, there was no documentation of resident's location or activity at the time of the check or interventions initiated to prevent falls. The facility's final report to the state agency dated 1/20/25 documents (R20) had an unwitnessed fall in room. (R20) stated to staff (R20) slid off the bed and complained of pain in the left wrist. (R20) was sent to (local hospital) emergency room . X-rays to Left wrist were completed and revealed fracture to Left Distal Radius. There is no root cause analysis documented as to the cause of (R20's) fall. On 1/24/25 at 3:00PM V3 (Registered Nurse/RN) stated I did the investigation. I don't recall what the root cause was. V3 verified a root cause must be determined to decide appropriate interventions to initiate to prevent more falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility's policy Fall Prevention revised 11/10/18 states Policy: To provide for resident safety and to minimize injuries related to falls; decrease falls and still honor resident's wishes/desires for maximum independence and mobility. Procedure: Conduct fall assessments on day of admission, quarterly, and with a change in condition. Identify, on admission, the resident's risk for falls. Assessment of fall risk will be completed by the admission nurse at the time of admission. Appropriate interventions will be implemented for residents determined to be at high risk at the time of admission for up to 72 hours. The admitting nurse will assign a temporary category. 41970 c.1.) R54's undated Face Sheet documents medical diagnoses as Dementia, Psychosis, Sensorineural Hearing Loss, Dependence on wheelchair, unsteady on feet and Dysphagia. R54's Minimum Data Set (MDS) dated [DATE] documents R54 as severely cognitively impaired. This same MDS documents R54 is dependent on staff for toileting, transfers, and maximum assistance for bathing, dressing and personal hygiene. R54's Physician Order Sheet (POS) dated January 2025 documents a physician order starting 6/24/24 with no end date for R54 to use Left siderail when R54 is in bed to enhance bed mobility. R54's Bed Rail/Transfer Bar consent dated 7/7/23 documents R54 has been assessed to benefit from a Left half siderail to be used at all times when resident is in bed. R54's Nurse Progress Note dated 12/13/24 at 4:01 AM documents R54 was calling out. R54 was in her bed, laying across the bed. R54's head was closer to the right side of the bed. R54's Lower extremities on the left side of the bed. R54's Left Lower Extremity (LLE) was caught in between the first and second bar on her half siderails. R54 stated she was trying to get up. No new injuries to LLE noted. On 1/21/25 at 10:00 AM R54 was laying in her bed with two half siderails in the up position. On 1/23/25 at 1:15 PM R54 was laying in her bed with two half siderails in the up position. On 1/22/25 at 2:45 PM V1 Administrator stated she was unaware that R54 had gotten her LLE stuck in the siderail. V1 Administrator further stated R54 is not supposed to use two siderails. V1 (Administrator) stated R54 could have easily been injured.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145584	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER Palm Garden of Mattoon		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on observation, interview, and record review the facility failed to prevent cross contamination during incontinence care. The facility also failed to maintain a urinary catheter drainage bag off the floor and in a dignity bag for two of three residents (R54, R1) residents reviewed for incontinence care and urinary catheters in a sample list of 33 residents. Findings include: 1. R54's undated Face Sheet documents medical diagnoses as Dementia, Psychosis, Sensorineural Hearing Loss, Dependence on wheelchair, unsteady on feet and Dysphagia. R54's Minimum Data Set (MDS) dated [DATE] documents R54 as severely cognitively impaired. This same MDS documents R54 is dependent on staff for toileting, transfers, and maximum assistance for bathing, dressing and personal hygiene. On 1/22/25 at 1:15 PM V6 and V7 (Certified Nurse Assistants/CNAs) completed incontinence care for R54. V6 and V7 both applied disposable gloves when removing R54's clothing and soiled incontinence brief. V6 and V7 both provided direct perineal care for R54. V6 and V7 did not use hand hygiene or change gloves throughout the entire procedure. On 1/22/25 at 1:30 PM V6 and V7 both stated they should have washed their hands and changed their gloves after removing R54's wet incontinence brief and before applying new brief. On 1/22/25 at 1:45 PM V1 (Administrator) stated staff should change gloves and wash their hands in between removing the wet incontinence brief and before applying a new brief. V1 stated R54 just recovered from a Urinary Tract Infection (UTI) and cross contaminating during incontinence care could cause R54 to have another UTI. The facility policy titled Perineal Cleansing revised 12/17 documents the basic infection control concept for perineal care is to wash from the cleanest to the dirtiest area and remember to change or remove gloves and wash hands when working with contaminated items to clean items. 20892 2. The Physician's Orders Sheet (POS) dated January 2025 lists diagnoses for R1 as Suprapubic Catheter, and Neuromuscular Dysfunction of the Bladder. On January 22, 2025 at 2:55 PM R1 was sitting in his recliner chair and R1's indwelling catheter bag was laying on the floor. The indwelling catheter bag was not covered with a dignity bag. On January 23, 2025 at 9:53 AM V12 (Certified Nurse Assistant/CNA) was to perform catheter care for R1. R1 refused for catheter care. V12 stated at 9:53 AM, when the resident is in the wheelchair or sitting in the recliner, we are to provide a dignity bag for the indwelling drainage bag to provide dignity and keep the bag off the floor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145584	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER Palm Garden of Mattoon		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility policy titled Urinary Drainage Collection Unit with revised date of 3/15/23 documents #20 in the policy Keep urinary drainage bag in a catheter cover (dignity bag). V1 (Administrator) stated on January 24, 25 at 12:30 PM, Yes all drainage bags for catheters are to be covered for dignity and should not be touching the floor.

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	01/24/2025

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on observation, interview, and record review the facility failed to employ a full time Director of Nurses (DON). This failure has the potential to affect all 83 residents residing in the facility. Findings include: The facility Daily Midnight Census Report dated 1/21/25 documents 83 residents reside in the facility. The Facility assessment dated ,d+[DATE] documents the facility will employ a full time Registered Nurse (RN) to be the DON. On 1/21/25-1/24/25 at various times during first and second shifts there was no DON onsite during survey timeframe. On 1/21/25 at 10:00 AM V1 (Administrator) stated the facility does not have a Director of Nurses (DON). V1 stated the facility has not had a DON for a few months and is currently looking to fill that position but have no prospects.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145584	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER: Palm Garden of Mattoon		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 37813 Based on observation, interview and record review the facility failed to identify/track resident specific targeted behaviors and failed to initiate resident centered interventions for one resident (R31) of five residents reviewed for Psychotropic medications in a sample list of 33. Findings Include: R31's Care Plan dated 12/17/24 includes the following diagnoses: Psychotic Disorder, Cerebral Infarction with Dominant Right sided Hemiparesis/Hemiplegia, Anxiety, Major Depression. Dysphagia, Muscle Weakness, Reduced Mobility. R31's Medication Administration Record for January 1, 2025 thru January 31, 2025 includes the following current physician's orders for psychotropic medications: 1. Lorazepam (antianxiety) Oral Concentrate 2 MG/ML Give 0.25 ml by mouth every 4 hours as needed for anxiety. 2. Seroquel (antipsychotic) Oral Tablet 25 MG Give 1 tablet by mouth in the morning for Anxiety/Agitation. Seroquel Oral Tablet 50 MG (Quetiapine Fumarate) Give 1 tablet by mouth at bedtime for agitation 3. Trazodone HCl (antidepressant) Oral Tablet 50 MG Give 0.5 tablet by mouth at bedtime for insomnia. In addition (R31) has the following current physician's order for opioid pain reliever: Morphine Sulfate (Concentrate) Oral Solution 20 MG/ML Give 0.25 ml by mouth every 2 hours as needed for Pain. There is no documentation in (R31's) electronic medical record to support specific targeted behaviors were determined or tracked. There is no documentation of resident specific nonpharmacological interventions attempted for (R31's) behaviors. On 1/21/25 at 12:00 PM and on 1/22/25 at 11:45 AM R31 was observed sitting at the dining room table without benefit of staff supervision. R31 appeared anxious and was muttering unintelligibly and flailing arms around. No staff were observed attempting interventions to alleviate R31's anxious behavior. On 1/24/25 at 3:00PM V4, Licensed Practical Nurse, Nurse Manager verified the facility utilizes a generic list of the same possible behaviors for all residents tracked for psychotropic medication and a generic list of the same possible interventions for behaviors. V4 stated That's all the (computer software) will let us do. The facility's policy Psychotropic Medication policy reviewed 9/16/24 states It is the policy of this facility that resident not be given unnecessary drugs. Unnecessary drugs is any drug that is used: 1. In an excessive dose. 2. For excessive duration 3. without adequate monitoring. 4. without adequate indications for use 5. In the presence of adverse consequences that indicate the drugs should be reduced or discontinued.