STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000416	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALM GARDEN OF MATTOON	1000 PALM , MATTOON, Illinois, 61938

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments Investigation of Facility Reported Incident of September 29, 2025/2638326	S0000		10/29/2025
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b)4)5) 300.1210c) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow	S9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000416	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALM GARDEN OF MATTOON	1000 PALM , MATTOON, Illinois, 61938

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 1 the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000416	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALM GARDEN OF MATTOON	1000 PALM , MATTOON, Illinois, 61938

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to develop and implement interventions to address behaviors to prevent a reoccurring injury following a fall that resulted in a partial finger amputation (R1). The facility also failed to supervise, implement fall interventions, and thoroughly investigate a fall (R3) for two of four residents (R1, R3) reviewed for falls in the sample list of four. This failure resulted in R3 experiencing an unwitnessed fall and coccyx fracture. Findings include: 1.) R3's 6/13/25 Minimum Data Set (MDS) documents R3 has moderate cognitive impairment and requires staff supervision/touch assistance for chair/bed transfers and walking at least 10 feet. R3's 9/9/25 MDS documents R3 has moderate cognitive impairment, had one fall with injury and one fall with major injury since the last review, and R3 requires supervision/touch assistance for transfers and partial/moderate assistance for walking. R3's active Care Plan documents the following: R3 has impaired cognition, short term memory loss, intellectual disability, dementia, disorganized schizophrenia, and psychotic disorder with delusions resulting in repetitive verbalizations/questions and memory loss related issues. R3 requires supervision or touching assistance for transfers. R3 has risk factors including impaired mobility/balance, impaired gait, mental illness, impulsive behaviors, extrapyramidal and movement disorder, a history of falls, and R3 requires monitoring and intervention to reduce the potential for self-injury. Interventions for 15-minute checks for safety and positioning was initiated on 9/10/24, a sign to "call before getting up" was placed in R3's bathroom initiated on 5/22/24, and a note was placed in resident's room that states to call for help before getting up initiated on 3/7/24. R3's unwitnessed fall report dated 7/18/25 at 11:00 AM, recorded by V4 (Licensed Practical Nurse/LPN), documents V4 was in the dining room passing medications during lunch, as V4 walked to the nurse's station R4 (R3's roommate) told V4 that R3 was saying "help." V4 immediately went into R3's room and found R3 sitting on her bottom on the floor with her knees pulled up towards her. R3's shirt was inside out over R3's head,	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000416	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALM GARDEN OF MATTOON	1000 PALM , MATTOON, Illinois, 61938

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 3 covering R3's face. This report documents injuries post incident as a coccyx fracture. The facility's investigative file for R3's fall, did not include documentation of when R3 was last checked on by staff, who last observed R3 or what R3 was doing when last observed prior to the fall. There is no documentation in this file that R3's 15-minute checks were implemented or if there were reminder signs posted in R3's room when R3 fell. The facility's initial report to the state surveying agency dated 7/18/25 documents R3 sustained a fall on 7/18/25 at 11:00AM that resulted in a hairline fracture of the pelvis and an investigation was initiated. The facility's final report of R3's injury, dated 7/22/25, documents R3's fall as noted above and R3 was sent to the hospital where a computed tomography (CT) found R3 had a subtle nondisplaced fracture involving the right upper coccyx segment. The root cause of the fall was R3 standing up in her room putting her shirt on when R3 lost balance and fell. The post fall intervention was to provide R3 with clothes that are easier to put on such as button up or with zippers. This report documents R3 will remain on 15-minute visuals and staff are to provide assistance when R3 is observed changing clothes. R3's CT of pelvis dated 7/18/25 documents reason for exam as fall with pelvic pain, findings indicate "probably mild osteopenia" and concern for hairline nondisplaced fracture involving the right aspect of the upper coccyx level. R3's Progress Note dated 9/22/25, recorded by V14 (Physician) documents "Coccyx fracture secondary to fall 7/18/25." On 10/14/25 at 12:46 PM R3 was sitting in a wheelchair in the hallway outside of R3's room. R3 was unable to give any details regarding her falls and stated, "I don't remember." R3 stated R3 does not need staff assistance for activities of daily living and R3 walks by herself. On 10/15/25 at 9:33 AM there were no signs posted in R3's room or bathroom to remind R3 to call for assistance before getting up. On 10/15/25 at 9:42 AM V4 (LPN) confirmed R3's unwitnessed fall on 7/18/25 and V4 found R3 sitting on the floor on her bottom in front of her closet. V4 stated R3 requires standby assistance from staff for transfers/walking. V4 entered R3's room/bathroom and confirmed there were no signs posted to remind R3 to call for assistance and there should be signs posted. V4 stated the signs must not have moved with R3 when R3 changed rooms. V4 stated R3 is noncompliant with	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000416	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALM GARDEN OF MATTOON	1000 PALM , MATTOON, Illinois, 61938

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 4 calling for assistance and R3 will get up and walk around and needs reminders to sit down and to ask for assistance. V4 stated R3 uses the call light often. At 12:00 PM V4 stated R3 had not had a room change in a very long time. V4 stated V4 was unsure when R3 was last checked on by staff or who had last seen R3 prior to her fall on 7/18/25. V4 confirmed R3 has an intervention for 15-minute checks which was an intervention prior to this fall. V4 stated 15-minute checks are documented on a paper form and that is not something the nurses document as part of the fall investigations. V4 stated V4 did not recall seeing the call reminder signs posted in R3's room the day R3 fell, and this is not something that V4 would have documented. On 10/15/25 at 10:51 AM V8 (LPN) stated V8 put reminder signs in R3's room on the bathroom door, the wall near the television and the wall near R3's dresser and R3 must have removed the signs. At 11:15 AM V8 stated V8 does the fall investigations and for R3's fall investigation V8 interviewed V4 (LPN), V15 and V16 (Certified Nursing Assistants/CNAs), who didn't see R3's fall. V8 confirmed prior interventions for 15-minute checks and signs should have been in place when R3 fell on 7/18/25. At 12:00 PM V8 verified all documentation regarding R3's 7/18/25 fall investigation was provided. V8 confirmed V8 did not know when R3 was last observed, who last observed R3 and R3's activity prior to R3's fall. V8 confirmed there was no documentation of this information in R3's fall investigation. V8 stated 15-minute checks are documented on paper form and V8 will look for the form for 7/18/25. At 12:50 PM V8 stated medical records staff were looking for R3's 7/18/25 15-minute check form. On 10/15/25 at 1:57 PM V14 (R3's Physician) stated V14 started seeing R3 as of 7/28/25 and R3 had a fall on 7/18/25 that resulted in a coccyx fracture, based on R3's progress notes. V14 stated R3's osteopenia puts R3 at risk for breaking any bones, and if R3 fell and landed on R3's buttocks it would be more likely to fracture R3's coccyx due to osteopenia. V14 confirmed R3 has poor recall ability. V14 stated fall prevention interventions for R3 should include reminder signs to call for assistance and a room close to the nurse's station to keep a "close eye on her (R3)." V14 confirmed R3 needs close supervision with frequent visual checks due to R3's impulsiveness and poor memory. V14 stated it is hard to say if the signs and visual checks would have 100% prevented R3's fall, but with the checks staff might have been able to lower R3 to the floor.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000416	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALM GARDEN OF MATTOON	1000 PALM , MATTOON, Illinois, 61938

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 5 On 10/15/25 at 3:26 PM V2 (Director of Nursing) stated V2 is still searching for R3's 15-minute check forms and had not found any documentation for 7/18/25. At 3:43 PM V2 stated V2 had not located R3's 15-minute check form for 7/18/25. 2.) On 10/14/25 at 12:15 PM R1 was sitting on the bed in his room. R1's left middle finger was red/swollen with a dark scab on the fingertip and missing the distal joint (end joint/tip). R1 was asked what caused R1's finger injury. R1 stated R1 fell at home and was unable to provide any additional details. R1 then put one of his fingers into his nose. The facility's final report dated 10/6/25, completed by V8 (LPN), documents R1's diagnoses include schizophrenia, anxiety disorder, extrapyramidal and movement disorder in diseases classified elsewhere, and unsteadiness on feet; and R1 has severe cognitive impairment. This report documents on 9/29/25 R1 had a witnessed fall in the Willow unit director's (V3) office. R1 had his finger in his mouth at the time of the fall which caused severe damage to the left third fingertip that required an almost complete surgical amputation of the fingertip on 9/30/25. R1's Operative Note dated 10/1/25 documents R1 sustained an almost complete traumatic amputation of the left fingertip of the middle finger, apparently due to biting his finger when he fell. X-rays showed a severely comminuted and markedly displaced fracture of the left distal phalanx of the left finger. The amputation was almost complete with a small bridge of tissue remaining that did not contain any vessel that could sustain reconstruction. R1 also had cognitive challenges and level of unawareness and a known history of removing dressings, therefore trying to do an open reduction internal fixation and leaving pins in place would be detrimental to the function of R1's hand. The decision was made to proceed with amputation of R1's finger at the level of the distal interphalangeal joint. The facility's investigative file for R1's 9/29/25 fall and injury did not include documentation that interventions were developed and implemented to address R1's behaviors of having R1's fingers in R1's mouth. R1's active care plan includes R1's fall on 9/19/25 and R1's fingertip injury, but does not include a problem, goals, and interventions to address R1's behaviors of having R1's fingers in R1's nose or mouth and to prevent further injuries to R1's fingers.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000416	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALM GARDEN OF MATTOON	1000 PALM , MATTOON, Illinois, 61938

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 6 On 10/14/25 at 10:25 AM V3 (LPN/MDS Coordinator) stated on 9/29/25 around 4-4:30 PM R1 was sitting on a folding chair in V3's office, R1 stood from the chair, lost his balance, then fell backwards into the chair and down the wall sliding to the floor onto his bottom. V3 stated R1 held up his left hand after the fall, R1's left middle fingertip was "just hanging," and R1 must have bit it off when R1 fell. V3 stated V3 believed R1's unsteadiness caused the fall. V3 stated R1 having R1's finger in R1's mouth made the fall a lot worse and the next day R1 had to have the rest of his fingertip amputated by an orthopedic surgeon. V3 stated R1 had no prior history of finger injuries. At 1:45 PM V3 confirmed R1 has a long history of putting R1's fingers in his mouth. V3 was asked about interventions and care planning for this behavior. V3 stated staff just tell R1 to keep his fingers out of his mouth. V3 confirmed this should be care planned. V3 stated V3 will update R1's care plan to include this behavior and interventions. On 10/14/25 at 1:55 PM V4 (LPN) stated R1 always has his fingers in his mouth, nose, or pants. V4 was asked what interventions are used to address these behaviors. V4 stated "we just try to tell (R1) to stop." V4 was unsure what new interventions were implemented following R1's fall and injury on 9/29/25. On 10/14/25 at 2:52 PM V6 (LPN) stated on 9/29/25 V6 was called to V3's office following R1's fall. V6 stated V6 found R1 sitting on the floor with a straight line cut across R1's finger and fingernail. V6 stated R1 must have had his finger in his mouth when R1 fell causing the injury. V6 stated it is common for R1 to have R1's fingers in his mouth, nose, or pants. V6 was asked about interventions to address this behavior. V6 stated staff frequently tell R1 to stop putting his fingers in his mouth and R1 will comply. V6 was unsure what new interventions were added after R1's fall injury. V6 stated V3 provided some fidget toys to keep R1's hands busy, but this was just initiated today. On 10/15/25 at 11:39 AM V8 (LPN) confirmed V8 completed the investigation of R1's 9/29/25 fall and injury. V8 stated R1 has a long history of putting R1's hands in his mouth despite staff reminding him not to do that. V8 stated "I don't know what we could have put in place to prevent (R1) from injuring his finger like that or to prevent it from happening again." V8 confirmed interventions were not developed/implemented to address R1's history of putting his fingers in his mouth and to prevent any additional injuries. The facility's Accident and Incidents - Investigating	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000416	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALM GARDEN OF MATTOON	1000 PALM , MATTOON, Illinois, 61938

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 7 and Reporting policy dated July 2017, documents the nurse supervisor or charge nurse will initiate and document an investigation of the accident or incident. This policy documents that the report of incident/accident form should include the circumstances surrounding the incident, corrective actions taken, follow-up information, and any other pertinent information as necessary or required. "A"	S9999		