

Illinois State Department of Health

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 01/29/2026	
NAME OF PROVIDER OR SUPPLIER PALM GARDEN OF MATTOON				STREET ADDRESS, CITY, STATE, ZIP CODE 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 Annual Licensure Survey Complaint Investigations: 25611856/2685259 25612179/2691694 25612473/2697539 2660598/2717136 2661100/2726942 Investigation of Facility Reported Incident of December 10, 2025/2695721			S0000			02/13/2026
S9999	Final Observations Statement of Licensure Violations 1 of 3: 300.610a) 300.3240a) 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent			S9999			02/13/2026

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to protect a resident's right to be free from staff to resident physical and emotional abuse which caused skin tears to the resident's arm and severe emotional distress. This failure affected one of three residents (R93) reviewed for abuse on the sample list of 39. Findings Include: The facility's Abuse Prevention Program dated February 2021 documents that the facility affirms residents' rights to be free from abuse. This includes freedom from physical restraint, mistreatment, or abuse of any resident. Abuse is defined as the willful infliction of injury, intimidation, or punishment resulting in harm, pain, or mental anguish. "Willful" means the individual acted deliberately; it does not require intent to inflict injury or harm. R93's Medical Diagnoses list dated January 2026 documents diagnoses of Congestive Heart Failure, right and left above-the-knee amputations, neuromuscular bladder dysfunction, generalized anxiety, depression, and a pressure ulcer of the buttocks. R93's Minimum Data Set (MDS) dated 1/2/26 documents R93 is cognitively intact, has no documented behaviors, requires substantial to maximum assistance with rolling side to side, and is dependent on staff for toileting hygiene. R93 has a urinary catheter and is always incontinent of bowel. R93's Abuse Final Report dated 1/13/26 documents R93 reported that two night-shift Certified Nursing Assistants (CNAs), V34 and V35, were rough with him during care. Both CNAs were agency staff and were not permitted to return to work at the facility. On 1/20/26 at 11:30 AM, R93 was observed sitting in his wheelchair in his room. R93 had a dressing on his right forearm. R93 stated that approximately one week prior, during the early morning hours, two CNAs entered his room to provide incontinent care. R93 stated he requires staff assistance with incontinence care due to			S9999			

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S9999	Continued from page 2 bilateral lower-extremity amputations. R93 stated he did not know the identities of the two CNAs, had never seen them prior to that night, and had not seen them since. R93 stated the CNAs called him derogatory names and pinned him down in bed by holding his arms. R93 stated he was incontinent with a large amount of diarrhea and that both CNAs were upset with him for requiring cleanup. R93 stated one CNA had very long fingernails, which caused skin tears on his arms. R93 stated he became very upset and yelled at the CNAs, calling them names. R93 stated he then took a drink of his pop, and the same CNA who had held his arms down struck his hand so hard that the drink flew out of his hand. R93 stated V1 (Administrator) informed him the two CNAs had been suspended and would not work at the facility again. On 1/28/26 at 1:29 PM, V25 (CNA) stated she arrived at work at 6:00 AM on 1/13/26 and heard R93 yelling from his room. V25 stated she went directly to R93's room and observed him crying uncontrollably. V25 stated she had never previously seen R93 cry and described him as extremely distraught. R93 told V25 he intended to report the night-shift CNAs for abuse and mistreatment. V25 stated it took some time for R93 to calm down. V25 stated R93 told her one CNA held his arms down and tore the skin on his arm. V25 stated she examined R93's arms and observed two fresh skin tears on his left arm, both shaped in a manner consistent with fingernail injuries. V25 stated R93 reported the CNAs removed the pillow from under his head while changing him and that after the incident, he told them to leave his room. V25 stated R93's bedding and pillow were covered in feces and feces were present on the floor. V25 stated R93 told her when he attempted to take a drink of his pop, the CNA who held his arms down struck the bottle, causing it to fly across the room. V25 stated the pop was dried and sticky on the floor, and the bottle was located across the room. V25 stated R93 admitted he yelled profanities at the CNAs because he was upset about how he was treated. V25 stated she had never known R93 to act in that manner, does not believe R93 makes false allegations, and stated R93 typically allows staff to provide care and does not refuse assistance. V25 stated R93 only wants to be treated respectfully and does not want to be left lying in his own feces. On 1/28/26 at 1:53 PM, V36 (Registered Nurse/RN) stated she was asked to complete a skin assessment on R93 following an allegation of abuse occurring on 1/13/26. V36 stated R93 reported night-shift CNAs grabbed his arms, held him down, and that a CNA's fingernails tore his skin. V36 stated she observed dried blood on R93's		S9999				

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S9999	Continued from page 3 left arm. V36 observed a skin tear on the left forearm and, adjacent to it, a crescent-shaped indentation that broke the skin and had blood present. V36 stated the injury appeared consistent with a fingernail. On 1/28/26 at 2:00 PM, V34 (Agency CNA) stated she worked with R93 on the night shift between 1/12/26 and 1/13/26. V34 stated she and another CNA (V35) entered R93's room to provide care and that R93 became upset. V34 stated R93 became combative and admitted she held his wrists down on the bed. V34 stated R93 was so upset that they were unable to complete care and left him soiled until the next shift. On 1/29/26 at 10:11 AM, V2 (Director of Nursing) stated staff should never antagonize a resident or restrain a resident by holding their arms. V2 stated R93 is typically very cooperative with staff and does not become upset when treated respectfully. V2 confirmed R93 is not known to make false allegations. V2 confirmed R93 alleged emotional and physical abuse and stated staff should never treat a resident in that manner. "B" Statement of Licensure Violations 2 of 3: 300.610a) 300.1210a) 300.1210b) 300.1210d)3)5) 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			S9999			

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S9999	Continued from page 4 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 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. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. This REQUIREMENT is not met as evidenced by:			S9999			

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S9999	Continued from page 5 Based on interview and record review the facility failed to implement pressure relieving measures timely, failed to complete a thorough skin assessment weekly and failed to prevent one (R107) resident's right heel pressure ulcer from worsening to a stage IV out of three residents reviewed for pressure ulcers in a sample list of 39 residents. R107 obtained a Stage IV pressure ulcer to her right heel at the facility. Findings include: R107's undated Face Sheet documents R107 was admitted to the facility on 11/27/24. R107's Electronic Medical Record (EMR) documents medical diagnoses of chronic respiratory failure with hypoxia, cognitive communication deficit, vitamin D deficiency, asthma with acute exacerbation, atelectasis, iron deficiency, delusional disorder, pulmonary embolism without acute cor pulmonale, morbid obesity, cellulitis of the right lower limb, fatty liver, hepatic encephalopathy, and a right heel Stage IV pressure ulcer. R107's Minimum Data Set (MDS) dated 2/19/25 documents R107 is moderately cognitively impaired. The MDS further documents R107 is dependent on staff for assistance with oral hygiene, bathing, dressing, toileting, personal hygiene, bed mobility, and transfers. R107's Pressure Risk Assessment dated 1/28/25 documents R107 was at risk for developing a pressure ulcer. R107's Nurse Progress Note dated 2/4/25 at 10:01 PM documents new open areas to R107's right heel. The note documents the right heel tissue was black with bloody drainage, red wound edges, and edema. R107's Skin-Only Evaluation dated 2/4/25 documents the plantar surface of R107's right heel had an open area measuring 0.9 cm long × 1.0 cm wide × 0.1 cm deep with bloody drainage and necrotic tissue. The evaluation further documents the posterior aspect of the right heel had an open area measuring 2.0 cm long × 2.0 cm wide, with no depth documented, and necrotic tissue with bloody drainage. The evaluation also documents		S9999				

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S9999	Continued from page 6 R107's left heel was red, with no measurements or further assessment documented. R107's Nurse Progress Note dated 2/13/25 at 2:41 PM documents V41 (Wound Physician) was notified of a wound care referral. The note documents a new physician order for R107 to wear a heel guard and that wound supplements were ordered for R107's right heel Stage III pressure ulcer. R107's EMR does not document a full wound assessment of R107's right heel pressure ulcer upon R107's return from the hospital on 2/13/25. R107's Wound Evaluation and Management Summary dated 2/20/25 documents an initial visit for R107's right heel Stage IV pressure ulcer measuring 4.0 cm long x 3.0 cm wide x 0.2 cm deep. On 1/27/26 at 3:05 PM, V10 (Licensed Practical Nurse/LPN), stated V41 (Wound Physician) saw R107 on 2/20/25 for her right heel. V10 stated she observed R107's right heel during wound rounds on 2/20/25 and that the wound appeared "worse" than when R107 returned from the hospital. V10 stated V41 categorized the wound as a Stage IV pressure ulcer on 2/20/25. On 1/28/26 at 11:10 AM, V7 (LPN) stated R107 had a "significant" pressure ulcer on her right heel. V7 stated the facility identified the wound on 2/4/25 as facility-acquired; however, R107 was hospitalized from 2/5/25 to 2/13/25. V7 stated R107 did not want to "do anything" and preferred to lie on her back in bed. V7 stated R107's heels rested directly on the bed for the majority of each day. V7 stated the facility should have obtained heel protectors upon R107's admission. On 1/28/26 at 2:10 PM, V18 (Regional Registered Nurse/RN), stated the facility was unable to provide documentation of a right heel wound assessment upon R107's readmission from the hospital. V18 stated the facility should document skin assessments, "especially" when a resident returns from the hospital. V18 stated the facility would provide education to nursing staff regarding timely assessments, interventions, and pressure ulcer prevention.			S9999			

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S9999	Continued from page 7 The facility policy titled Pressure Ulcers/Skin Breakdown – Clinical Protocol, revised April 2018, documents the nurse shall describe and document a full assessment of a pressure ulcer, including location, stage, length, width, depth, and the presence of exudate or necrotic tissue. The policy further documents staff and practitioners will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions. "B" Statement of Licensure Violations 3 of 3: 300.610a) 300.1210b)4)5) 300.1210d)6) 300.2210b)5) 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 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		S9999				

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S9999	Continued from page 8 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. 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. Section 300.2210 Maintenance b) Each facility shall: 5) Maintain all furniture and furnishings in a clean, attractive, and safely repaired condition. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement fall prevention interventions and failed to maintain a safe environment for two residents (R7 and R107) out of six residents reviewed for falls in a sample of 39 residents. R107 experienced pain and fear as a result of falling, as well as a closed head injury and multiple contusions following a fall on 1/1/25. R107 required further evaluation of her injuries in an emergency room following falls on 1/1/25 and 1/8/25 due to having a physician order for Xarelto (anticoagulant therapy).			S9999			

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S9999	Continued from page 9 Findings include: 1.R107's Electronic Medical Record (EMR) documents medical diagnoses as Chronic Respiratory Failure with Hypoxia, Systolic Heart Failure, Schizophrenia, Cognitive Communication Deficit, Vitamin D Deficiency, Atelectasis, Iron Deficiency, Delusional Disorder, Pulmonary Embolism without acute Cor Pulmonale, Morbid Obesity, Cellulitis of Right Lower Limb, and Hepatic Encephalopathy. R107's Minimum Data Set (MDS) dated 2/19/25 documents R107 as moderately cognitively impaired. This same MDS documents R107 as being dependent on staff for assistance with oral hygiene, bathing, dressing, toileting, personal hygiene, bed mobility and transfers. R107's Fall Care Plan initiated 12/19/24 documents the root cause of R107's falls as dizziness upon standing. R107's Care Plan intervention dated 1/4/25 documents R107 is to utilize a wheelchair. This same Care Plan documents an intervention dated 1/8/25 for staff to assist R107 to the dining room and assist R107 to a chair. This same Care Plan documents an intervention dated 2/28/25 to keep a bedside table for personal items within reach. R107's Fall Risk Evaluation dated 12/18/2024 documents R107 as being a high fall risk. R107's Physician Order Sheet (POS) dated January and February 2025 document a physician order starting 11/27/24 for Rivaroxaban (anticoagulant) 15 milligrams (mg) twice daily for Pulmonary Embolism. R107's Nurse Progress Note dated 1/1/2025 at 1:02 PM documents R107 had an unwitnessed fall in the resident common area. This same note documents R107 stated she attempted to stand, felt dizzy, fell and hit her head. This same note documents R107 was noted to have a large purple bruise on her Coccyx/Sacral area. This same note documents R107 was sent to the hospital for evaluation. R107's fall investigation dated 1/1/25 documents R107 had an unwitnessed fall in the resident common area. This same fall investigation documents R107 tried to stand up, felt dizzy and fell back and hit her head on the floor. This same investigation documents R107 was sent to the emergency room for further evaluation due to R107 takes an anticoagulant. R107's Hospital Record dated 1/1/25 documents R107 fell			S9999			

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S9999	Continued from page 10 at the facility obtaining a closed head injury, cervical strain and contusions of her Left Knee, Right Knee, Left Forearm and Left Shoulder. R107's Nurse Progress Note dated 1/1/25 at 9:00 PM documents R107 returned to the facility. This same note documents R107 obtained a status post fall closed head injury, cervical strain, contusion of Left Knee, Right Knee, Left Forearm and Left Shoulder. This same note documents physician orders to rest, apply ice, elevate affected extremities and wear ace wrap to Left Forearm and bilateral knees. R107's Nurse Progress Note dated 1/5/25 at 1:07 PM documents R107 stayed in her room all shift. This same note documents R107 stated 'I'm scared to come out because I don't want to fall. I'm not coming out.' R107's Nurse Progress Note dated 1/7/25 at 6:16 PM documents R107 refused to get out of bed unless up in a wheelchair. This same note documents R107 stated she is not coming out (of her room) due to she is scared of falling. This same note documents R107 refused to take herself to the bathroom and is choosing to soil herself. R107's Nurse Progress Note dated 1/8/25 at 12:43 PM documents R107 was walked to the dining room with staff assistance. This same note documents R107 walked over to a different chair and fell to the floor. This same note documents this fall was witnessed by V43 (Certified Nursing Assistant/CNA) who stated she 'watched (R107's) head bounce off of the floor'. R107's fall investigation dated 1/8/25 documents R107 had a witnessed fall in the facility dining room. This same fall investigation documents R107 was walking independently to move to another chair and R107 missed the chair falling to the floor and hit her head. R107's Hospital Record dated 1/8/25 documents R107 obtained a Hematoma to the posterior aspect of R107's scalp due to her falling on 1/8/25 at the facility. R107's Fall Investigation dated 2/28/25 documents R107 had an unwitnessed fall out of her bed because she was reaching for candy due to R107 did not have a bedside table. R107's fall investigation dated 2/28/25 documents R107 had an unwitnessed fall in her room. This same investigation documents R107 was found on the floor with feet towards the window and head propped up on the side of the bed. Investigation documents R107 stated			S9999			

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S9999	Continued from page 11 'she was reaching for a piece of candy and slid out of bed'. This same investigation documents R107 did not have any injuries. R107's Nurse Progress Note dated 3/1/25 at 5:56 PM documents the root cause of R107's unwitnessed fall on 2/28/25 as R107 was reaching for her personal items at her bedside and slid out of bed. This same note documents the intervention for R107's fall was to keep a bedside table at R107's bedside. On 1/27/26 at 3:00 PM V10 (Licensed Practical Nurse/LPN) stated R107 fell out of her bed on 2/28/25 due to R107 was trying to reach over to her bedside dresser to get some candy. V10 stated R107 did not have a bedside table in her room. V10 stated if R107 had a bedside table she would not have had to reach so far and most likely not fallen out of her bed. V10 stated it is standard for all residents to have a bedside table and there was no reason R107 did not have a table to put her personal belongings on. R107's fall on 2/28/25 could have been prevented if R107 had a bedside table. V10 stated since R107 was on a low air loss mattress R107 should have had a bedside table to prevent her from falling out of bed. On 1/28/26 at 11:05 AM V7 (LPN) stated she was R107's nurse regularly. V7 stated the staff knew R107 had been dizzy every time she stood up and 'really nothing had been done about it'. V7 stated the staff should have been monitoring R107 closer since 'we knew she was sitting on the bench, and she would be going to the dining room for lunch'. V7 stated R107 hit her head on the hard floor then complained of a headache so she was sent to the emergency room. V7 stated R107 had a 'large' bruise on her Sacral area. R107's fall on 1/1/25 could have been prevented with closer supervision due to the staff knew for 'a few days' that R107 was not feeling good and complained of dizziness with standing. V7 stated R107 fell again on 1/8/25 after therapy walked R107 to the dining room but did not leave a wheelchair for her to use. V7 stated R107 was supposed to use a wheelchair at that point and she did not have one to use. V7 stated R107 wanted the wheelchair and would have used it instead of trying to walk. V7 stated R107 was scared to walk alone and would have used the wheelchair. V7 stated R107's fall on 1/8/25 could have been prevented if R107 had a wheelchair accessible. V7 stated R107 wanted to use the wheelchair due to her fear of falling again. On 1/29/26 at 9:50 AM V18 (Regional Registered Nurse/RN) stated the facility does not have any documentation to show that fall interventions were in		S9999				

Illinois State Department of Health

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 01/29/2026	
NAME OF PROVIDER OR SUPPLIER PALM GARDEN OF MATTOON				STREET ADDRESS, CITY, STATE, ZIP CODE 1000 PALM , MATTOON, Illinois, 61938			
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S9999	Continued from page 12 place at the time of R107's falls. V18 stated all residents should have a bedside table. V18 stated that it is a standard piece of equipment and does not know why R107 did not have a bedside table in her room. V18 stated staff should have been supervising R107 if they had known she was complaining of being dizzy when standing. V18 stated a wheelchair should have been left with R107 in the dining room so she wouldn't have walked over to another chair. V18 stated the staff should follow the interventions put into place to help reduce a resident's falls. The facility policy titled Falls-Clinical Protocol revised March 2018 documents After a first fall, the staff (and physician, if possible) should watch the individual rise from a chair without using his or her arms, walk several paces, and return to sitting. If the individual has no difficulty or unsteadiness, additional evaluation may not be needed. If the individual has difficulty or is unsteady in performing this test, additional evaluation should occur. 2. R7's Medical Diagnoses list dated January 2026 documents R7 is diagnosed with Chronic Obstructive Pulmonary Disease, Fractured Left Tibia, Disorder of Muscles, Lack of Coordination, Gait Abnormalities, Muscle Wasting, Phantom Limb Syndrome, and Right Above the Knee Amputation. R7's Physician Order Sheet dated January 2026 documents a physician order for a left half side rail in the up position while in bed to enhance bed mobility. Staff should check positioning and functioning of device. R7's Health Status Note dated 12/17/25 documents R7 was heard yelling from her room. Staff went in to check on R7 and found her sitting on the floor by her bed. The left side rail was on the floor beside her. R7 stated she attempted to sit up on the side of the bed, using the side rail, when it fell off the bed frame, causing R7 to fall with it onto the ground. On 01/22/2026 10:45 AM V15 (Maintenance Director) stated nursing staff often remove or replace side rails on resident's beds and do not secure them to the bed frames properly. V15 stated this is what he believes happened when R7's bed rail came off the frame and caused her to fall. V15 confirmed the bed rail was not properly secured.			S9999			

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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 01/29/2026	
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S9999	Continued from page 13 On 1/22/26 at 3:00 PM V2 (Director of Nurses) confirmed only maintenance staff are to remove and install bedrails. V2 confirmed the bedrails need to be installed correctly to be safe and not pose a hazard for residents. V2 confirmed when R7 fell from her bed on 12/17/25, her bed rail came off the bed when she attempted to use it. V2 confirmed the bed rail must not have been secured and therefore posed a hazard which resulted in R7 falling onto the floor. "B"		S9999				