STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002109	A. BUILDING: _____ B. WING _____	C 04/25/2025

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PALM GARDEN OF MATTOON	1000 PALM MATTOON, IL 61938

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S 000	Initial Comments Investigation of Facility Reported Incident of April 23, 2025/IL190775	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210d)3) 300.3210t) 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	S9999		

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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.

Section 300.3210 General
t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

This REQUIREMENT is not met as evidenced by:

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A. Based on observation, interview, and record review the facility failed to protect one (R4) resident's right to be free from verbal and mental abuse and being physically threatened by another resident (R5) which was witnessed by a resident (R6) out of nine residents reviewed for abuse in a sample list of 12 residents. R4 was made to cry, feel sad and scared causing her to be fearful of being physically abused.

B. Based on observation, interview, and record review the facility failed to protect one (R4) resident from being repeatedly verbally and mentally abused by another resident (R5) throughout an entire day while the staff were aware of R4 being abused. Two residents (R4, R5) were affected by this failure out of nine residents reviewed for abuse in a sample list of 12 residents. R4 felt scared causing her to change her activity routine in fear of being further abused by R5.

Findings include:

R4's undated Face Sheet documents medical diagnoses as Bipolar Disorder, Anxiety, Non-Rheumatic Mitral and Pulmonary Valve Insufficiency, Chronic Diastolic Congestive Heart Failure, Syncope and Collapse.

R4's Minimum Data Set (MDS) dated 3/8/2025 documents R4 as cognitively intact.

R5's Minimum Data Set (MDS) dated 1/28/25 documents R5 as cognitively intact. This same MDS documents R5 requires supervision with dressing, bathing, personal hygiene, bed mobility and transfers.

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R5's Nurse Progress Note dated 4/22/25 at 9:49 AM document "(R5) sat next to (R4) and began to talk to (R4). (R4) said she did not want to talk to (R5) at that time. (R5) got upset and called (R4) a b**** (expletive). Then (R5) started yelling and screaming at (R4)."

R6's Minimum Data Set (MDS) dated 4/3/25 documents R6 as cognitively intact.

R4's Initial Report to the State Agency documents R5 allegedly verbally abused R4 on 4/22/25.

R4's initial Abuse Investigation dated 4/23/25 documents R5 told R4 to 'stay away from my man you b**** (expletive) and then R5 swung at R4. This same investigation documents R4 was sitting with R6 when R5 said R5 wanted to go to bed with R6. This same file documents R4 was walking down the hall after supper and R5 said 'stay away from me b**** (expletive)'.

R4's Nurse Progress Notes do not document any altercation with R5 on 4/21/25 nor 4/22/25.

R4's Care plan initiated 6/13/24 does not include a focus area, goal nor interventions of R4's risk of being abused.

On 4/23/25 at 9:45 AM R4 stated on 4/21/25 R4 went out to the commons area after breakfast. R4 stated R5 came up to her and wanted to talk. R4 stated she didn't feel like talking right then so R4 told R5 to go away. R4 stated R5 was not happy with R4 for not talking to R5 but R5 did leave the area. R4 stated the next day (4/22/25) R5 walked up to R4 and R6 after breakfast when R5 began screaming and yelling profanities at R4 with R6 present. R4 stated "She (R5) was saying

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awful things. (R5) called me a b**** (expletive) and told me to 'go f*** (expletive) myself." R4 stated she began crying as R5 continued to yell and scream at R4 in front of R6. R4 stated finally R5 walked away. R4 stated she was very embarrassed because R5 was saying 'awful' things to her in front of R6. R4 stated R5 told R6 that R5 wanted to have sex with R6. R4 stated R6 refused R5's sexual advances. R4 stated her and R6 are good friends and do not need any other close friends coming between her and R6. R4 stated R5 made her feel scared. R4 was crying during the interview. R4 stated "Please don't let (R5) come near me again. I am so scared (R5) will hurt me. (R5) told me she would hurt me bad. I believe (R5). (R5) is a lot bigger than me. (R5) could knock me over and hurt me. I am supposed to walk up and down the halls to exercise my hip. I don't walk down (R5's) hall because I am afraid (R5) will see me and beat me up. (R5) is unpredictable and crazy. I don't want (R5) anywhere near me." R4 stated "After lunch that day (4/22) (R5) walked up and started yelling at me. Calling me a b**** (expletive) and telling me how bad I am at sex things. Then (R5) swung her whole arm at me. (R5) didn't actually hit me but I was so scared. I just kept yelling 'Get her off of me! Help me! (R5) is trying to kill me!' R4 stated the staff, including V9 (Psychosocial Rehabilitation Director/PRSD) was aware that R5 kept walking up to R4 to yell obscenities at R4. R4 stated V8 (Psychosocial Rehabilitation Counselor/PRSC) and V9 (PRSD) were aware of R5's behaviors on 4/22/25. R4 stated the facility did not do anything to help R4 so she told V19 (Registered Nurse/RN) the next morning (4/23/25). R4 stated she did not sleep the night of 4/22/25 for fear R5 would come into her room and attack her. R4 stated R5 lived right across the hall from her at that time so R5 could easily

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walk over into R4's room to hurt her. R4 stated "I know (V19) Registered Nurse (RN) would help me, so I waited for her to come into work the next morning (4/23/25) and told her what happened."

On 4/23/25 at 10:25 AM V18 (Psychosocial Rehabilitation Assistant/PRSA) stated R4 was crying hysterically after being screamed at by R5. V18 stated he verbally consoled R4 and then later when R4 was still upset about the matter, the staff allowed R4 to call her sister to help console her also.

On 4/23/25 at 11:10 AM V21 (PRSA) stated R5 was 'out of control' on 4/22/25 due to the way R5 was treating R4. V21 stated she heard R5 tell R4 to 'Shut the F*** (expletive) up!' and 'I'll beat you're a** (expletive)!'. V21 stated R5 should have been put on a one-to-one observation but was not. V21 stated R5 kept returning to R4 throughout the day to yell at R4.

On 4/23/25 at 12:00 PM R4 left the main dining room for the unit and walked towards the resident hallways. R4 walked down to the end of her hallway, turned around and walked back to the center resident commons area. R4 did not walk down the opposite hallway where R5 resides. R5 left the dining room a few minutes later, stopped in the same commons area, looked towards R4, and then proceeded to her own room. No staff were present in the dining room nor in the commons area.

On 4/23/25 at 12:40 PM R5 stated R5 yelled, screamed, and cursed at R4 because R4 would not talk to her the day before (4/21/25). R5 stated R4 was in a bad mood so R5 called R4 a b**** (expletive). R5 stated she wished R5 would have hit her when R5 swung at R4. R5 stated "I

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would have hit (R4) right to the ground." R5 stated she tried to 'get with' R6 to make R4 mad but R6 didn't want to be with R5 and that made R5 even more mad. R5 stated she 'went after' R4 several times that day and told R4 what a b**** (expletive) R4 is.

On 4/23/25 at 1:40 PM V9 (Psychosocial Rehabilitation Director/PRSD) stated on 4/22/25 after breakfast she heard R5 yelling and screaming in the resident commons area. V9 stated she was in her office right next to the resident common area. V9 stated she went out to see what was going on and saw R5 yelling at R4 and R6 as R5 was walking away from R4. V9 stated she heard R5 call R4 a b**** (expletive). V9 stated R5 was so loud it was hurting her ears. V9 stated R5 told V9 that she had to tell off R4 because R4 is racist. V9 stated V9 told R4 that R5 did not mean anything R5 said. V9 stated R4 was crying, tearful and stating she was very scared of R5. V9 stated R6 stated he heard R5 call R4 a b**** (expletive) and to 'get the f*** (expletive) out of R5's way'. V9 stated R4 calmed down after about an hour. V9 stated R5 went back to her room and V9 went back to her office. V9 stated she is the director of the psychiatric locked down unit and was never told that she had to report verbal and/or mental abuse to V1 (Abuse Coordinator/Administrator). V9 stated after lunch R5 walked up to R6 and stated R5 could do R6 'sexual favors' better than R4. V9 stated this made R5 mad so she started yelling at R4 and R6 again. V9 stated R5 called R4 a b**** (expletive). V9 stated V8 (Psychosocial Rehabilitation Counselor/PRSC) then came out to help de-escalate R5. V9 stated R4 was terrified and tearful after being yelled at by R5. V9 (PRSD) stated V9 was aware that R5 walked up to R4 multiple times throughout the day (4/22/25) to yell

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and scream profanities at R4 due to R4 did not talk to R5 the day before (4/21/25). V9 stated she should have separated R5 from everyone until they (staff) could figure out what had happened and to ensure the safety of R4. V9 stated R4 could have been hurt. V9 stated R5 did threaten to hurt R4 and 'you never know if a threat is real or not until something happens'. V9 stated R5 was placed on 15-minute checks on 4/23/25 at 11:00 AM. V9 stated R5 should have been placed on a one-to-one continuous observations due to her repeatedly abusing R4.

On 4/24/25 at 12:10 PM R4 and R5 were sitting in the dining room at the same time during lunch service. R5 stood and walked by R4. There were no staff in the dining room at that time.

On 4/25/25 at 1:00 PM V24 (Nurse Practitioner/NP) stated R5 yelling, screaming derogatory words, and attempting to hit R4 could have a negative effect on R4. V24 stated R4 could experience Post Traumatic Stress Disorder (PTSD), Anxiety and Insomnia caused by R5 verbally and mentally abusing R4. V24 stated R5 humiliated R4 in front of her close friend R6 which could cause R4 to have regressive behaviors. V24 stated mentally ill residents such as R5 do have behaviors but this instance of R5 verbally and mentally abusing R4 would be considered abuse.

On 4/25/25 at 1:10 PM V24 (NP) stated R5 should have been sent to the emergency room for a psychiatric evaluation by a physician. V24 stated R5 isn't known to have those kinds of behaviors. V24 stated R5 could have had some clinical issue happening or R5 could have been going through some type of new mental health issue that she had not experienced before. V24

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stated R4 was not protected by this facility due to R5 was not monitored closely enough if R5 was allowed to repeatedly abuse R4 verbally and mentally.

On 4/25/25 at 2:30 PM V20 (Regional Director of Operations) stated the staff should have monitored R5 more closely after they were aware that R5 had yelled at R4 after breakfast on 4/22/25. V20 stated R4 was not protected from R5's repeated abuse and should have been.

On 4/25/25 at 2:35 PM V20 (Regional Director of Operations) stated the facility should have communicated better in order to monitor R5 for behaviors. V20 stated the staff were aware R5 was upset with R4 on the day before (4/21/25) R5 abused R4. V20 stated these incidents could possibly have been avoided if the staff were paying closer attention. V20 stated the locked unit houses mentally ill individuals who need extra support and monitoring to prevent these types of things from happening. V20 stated the facility is re-training their staff on the facility Abuse policy and behavior management to reduce abuse.

The facility policy titled Abuse Prevention Program revised 11/28/2016 documents the facility affirms the right of our resident to be free from abuse, neglect, misappropriate of resident property, and exploitation as defined below. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Abuse is the willful injection of injury, unreasonable confinement, intimidate, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual including a caretaker, of good or

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services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Verbal abuse is the oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance regardless of their age, ability to comprehend or disability. Examples of verbal abuse include, but are not lied to, threats of harm, or saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again. Mental abuse includes, but is not limited to, abuse that is facilitated or caused by nursing home staff taking or using photographs or recordings in any manner that would demean or humiliate a resident, harassment, humiliation and threats of punishment or deprivation.

The facility policy titled Abuse Prevention Program revised 11/28/2016 also documents residents who allegedly mistreat or abuse another resident or misappropriate resident property will be removed from contact with that resident during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches and placement considering his or her safety, as well as the safety of other residents and employees of the facility.

"B"