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 08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALM TERRACE OF MATTOON	1000 PALM MATTOON, IL 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) COMPLETE DATE
S 000	Initial Comments Complaint Investigation: 2366540/IL162932	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b)4)5) 300.1210d)3)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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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. 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. 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:	S9999		

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S9999	Continued From page 2 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. 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to implement resident centered fall prevention interventions following a fall for one resident (R4) of three residents reviewed for falls in a sample list of five residents. This failure resulted in R4 falling and sustaining an ankle fracture. Findings Include: R4's diagnoses list printed 8/14/23 at 2:05PM includes the following diagnoses: Neuroleptic Induced Parkinsonism, Seizures, Essential Hypertension, and Paranoid Schizophrenia. R4's Minimum Data Set (MDS) dated 7/7/23 documents R4 scored a 15/15 on the Brief Interview of Mental Status (BIMS) indicating R4 is cognitively intact. R4's Care Plan includes a risk for fall initiated and	S9999		

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S9999	Continued From page 3 continued since 4/2/20. A note was added 5/15/23 documenting "(R4) stated (R4) fell in room and was having difficulty seeing. (R4) received new glasses recently. Remind (R4) to change position slowly." This is the only updated to R4's fall Care Plan since 4/2/20. R4's Physical Therapy Plan of Care initiated 5/16/23 documents R4 required therapy "due to a fall on 5/12/23 as a result of patient losing her balance during walking resulting in right knee abrasion. Patient has complaints of right knee pain with resulting impairments in strength, balance, safety awareness, and decreased functional mobility. Therapy is necessary to regain lost function and reduce falls. Without therapy, patient is at risk for falls and further decline in function." This Physical Therapy Plan of Care also documents "Discharge Plans: Remain in Skilled Nursing Facility with restorative nursing program." The end of care date for Physical therapy is documented as 7/3/23. There is no documentation to support a restorative program or any other fall prevention interventions were added to R4's Care Plan following discontinuation of therapy. R4's Progress Note dated 7/20/23 at 12:30AM documents (R4) experienced an unwitnessed fall in (R4's) room while ambulating from bathroom back to bed. The note documents "(R4's) account of the event is (R4) stated (R4) fell returning from bathroom while ambulating; unable to recall how (R4) landed when (R4) fell." R4's Progress Note dated 7/20/23 at 4:25AM documents "(R4) returned from (Local Hospital) Emergency Room with Diagnosis: Fracture of right lateral malleolus." (ankle)	S9999		

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S9999	Continued From page 4 On 8/14/23 at 1:46PM R4 was seated in her room alone in a recliner with her feet elevated. A fiberglass cast was visible above her pants on her right ankle/foot. R4 stated "I fell on July 20th. I got up to go to the bathroom with my walker and as I was trying to get through the bathroom door and my walker got tangled up and I fell and broke my ankle. I told the staff I was falling more. They gave me therapy for a while. It helped. Now I'm weaker again and I have this cast." On 8/15/23 at 12:00PM V10 (Physical Therapy Assistant/PTA) stated "We did teaching with (R4) and the floor staff related to (R4's) home exercise plan which should have been initiated after (R4) met her goals to maintain (R4's) safety and balance." On 8/15/23 at 2:25PM V11 (Nurse Practitioner) stated "(R4's) fall caused the fracture of her ankle. It would have been my expectation that after therapy was discontinued the facility would put interventions in place to help (R4) maintain her safety." On 8/15/23 at 2:00PM V12 (Certified Nurse's Aide/CNA) stated "I know (R4) pretty well. I am assigned to her unit for this shift. (R4) doesn't have any restorative programs." 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 each resident's wishes/desires for maximum independence and mobility. Immediately following any resident fall the unit nurse will assess the resident and provide any care or treatment needed for the resident. A fall huddle will be conducted with staff on duty to help identify circumstances of the	S9999		

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S9999	Continued From page 5 event and appropriate interventions. The unit nurse will place documentation of the circumstances of the fall in the nurse's notes or on the AIMS (Assessment, Intervention, Monitor) for Wellness form along with any new intervention deemed to be appropriate at the time. The unit nurse will also place any new interventions on the CNA assignment worksheet. Report all falls during the morning quality assurance meeting Monday through Friday. All falls will be discussed in morning quality assurance meeting and any new interventions will be written on the care plan." "B"	S9999		