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 02/22/2023

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 Investigation of Facility Reported Incident of January 30, 2023/IL156421	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b)4) 300.1210d)6) 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 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. 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 interview and record review, the facility failed to ensure safe footwear and effective supervision of R4 while dressing. This failure resulted in R4 slipping and falling to the ground sustaining a forehead laceration, brain bleed, brain bruising, nasal fractures, and eye socket fractures requiring emergency medical treatment at two hospitals. R4 is one of three residents reviewed for falls in the sample of six. Findings include: R4's Physician Orders (January 2023) document R4's diagnoses include Dementia, Osteoarthritis (degenerative joint disease), Osteopenia (reduced bone density), Hypotension (low blood pressure), and Near Syncope (near-fainting). R4's Minimum Data Set documents R4 is dependent upon staff for cares, requiring complete dependence on staff for bathing and weight-bearing support from staff while dressing. The facility incident report (2/3/2023) documents R4 sustained a witnessed fall on 1/30/2023 after showering. The report documents V11 (Certified Nurse Assistant) had showered and partially dressed R4 and assisted R4 to a standing position when R4 slipped and fell to the ground	S9999		

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S9999	Continued From page 2 sustaining multiple injuries requiring emergency medical treatment at the hospital. The report documents R4's non-slip socks at the time of the fall were missing portions of the non-slip surface on the bottom of the socks and the facility concluded the socks were the root cause of R4's fall. R4's hospital reports (1/30/2023) document R4 was initially sent to a local hospital for emergency medical evaluation and treatment. The local hospital's assessment of R4 documented R4 sustained injuries during a witnessed fall including a forehead laceration, periorbital (eye socket) bruising, left and right-side brain contusions (bruising), brain hematoma (bleed), left and right-side nasal bone fractures, and right-side orbit (eye socket) fracture. The report documents R4 required neurosurgical medical evaluation, trauma services, and otorhinolaryngology services and was transferred to a regional hospital capable of the additional evaluation and treatment. The reports document the regional hospital sutured R4's forehead laceration and R4 was admitted there for continued neurological assessment following R4's brain injuries. R4's Physician Orders (February 2023) document R4 required ongoing neurological assessment and wound treatment at the nursing home following R4's discharge from the hospital after R4's 1/30/2023 fall. On 2/21/2023 at 2:50PM, V12 (Registered Nurse) reported V12 was present in the shower room after R4 fell to the ground on 1/30/2023. V12 recalled V11 reported showering then dressing R4, turning around, then R4 fell to the ground.	S9999		

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S9999	Continued From page 3 On 2/22/2023 at 10:00AM, V13 and V14 (both R1's family) reported the facility contacted them after R4's fall on 1/30/2023 and their understanding was V11 was dressing R4 after a shower, then V11 turned away from R4 when R4 fell to the ground. On 2/22/2023 at 10:31AM, V11 (CNA) reported R4 does not have good balance sometimes and R4 gets R4's legs "tangled" often. V11 reported two staff are usually present when dressing and undressing R4 during perineal cares. V11 reported R4 is not combative unless changing clothes, and R4 was combative the day of R4's fall on 1/30/2023. V11 stated "(R4) had grippers (non-slip socks) on (at the time of the fall), but the socks didn't have the good grip (the rubber patterns found on the bottom of non-slip socks) on and that probably made it worse, and it seemed like (R4) slipped and (R4's) leg got twisted." V11 reported "I may have had a towel beneath (R4's) feet (at the time of the fall)." V11 stated "I saw (R4's) legs cross and (R4) went to pull a foot out and it (R4's foot) didn't (pull free) and (R4) went hard (falling to the floor)." V11 reported R4 does not have good balance when staff change R4's clothes, and when staff touch R4, R4 seems irritated. V11 could not recall if R4 leans on V11 for weight-bearing support while staff dress R4. On 2/22/2023 at 3:18PM, V2 (Quality Assurance Registered Nurse) reported the root cause of R4's fall was due to the non-slip surface of R4's socks being worn down. "A"	S9999		