

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145584	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/24/2025
NAME OF PROVIDER OR SUPPLIER Palm Garden of Mattoon		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 Palm Mattoon, IL 61938	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42702</p> <p>Based on interview and record review the facility failed to ensure that a current copy of one (R3) resident's advance directive of three reviewed was accessible and in the resident's medical record during a medical emergency resulting in the facility staff delaying cardiopulmonary resuscitation.</p> <p>Findings include:</p> <p>The facility provided Advance Directive Policy dated [DATE] documents that any decision regarding advanced directives shall be indicated in the chart in the manner easily understood by all staff. Code staff shall be recorded on the resident's physician order sheet. The implementation of a code includes the review of the chart to determine code status.</p> <p>R3's progress notes dated [DATE] document that R3 was admitted to the facility.</p> <p>On [DATE], R3's electronic medical record does not document R3's code status, nor is there a physician order indicating code status.</p> <p>R3's Minimum Data Set, dated dated dated [DATE] documents R3 is severely cognitively impaired and primarily non-verbal.</p> <p>R3's progress notes dated [DATE] document that at approximately 11:00AM, R3 choked on the regular chicken provided, in the dining room. V9 and V10 (Certified Nursing Assistants/CNA) immediately attempted the Heimlich Maneuver without success. V11 (Licensed Practical Nurse/LPN) looked for R3's code status in R3's hard chart and in the electronic medical record. When none was found, V11 obtained the crash cart, placed R3 on 15 liters of oxygen via ambu bag and cardiopulmonary resuscitation (CPR) was started until the emergency medical technicians arrived and took over. R3 had no respirations, and his pulse rate was 30 beats per minute when CPR was begun.</p> <p>On [DATE] at 1:15PM, V11 (LPN) stated, I was in the bathroom next to the dining room and heard them yell for help. They told me that he was choking. I couldn't find his code status in the computer then I went to look for his chart and when I couldn't find the code status, I grabbed the code cart. When I returned with the cart (R3) was no longer breathing and his pulse rate was 30.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 10:38AM, V9 (CNA) stated that she was in the dining room passing drinks when R3 came up behind her and patted her shoulder. She asked him what was wrong, and he didn't answer. R3 then patted his stomach and V9 realized that R3 was choking. I began the Heimlich Maneuver on R3 with V13 (Psychiatric Rehabilitation Services Coordinator/PRSC) helping me because R3 was a pretty big guy. We couldn't get enough out doing the Heimlich, so we yelled for a nurse to get in there and I saw R3's lips turned purple. We sat him in a chair because he couldn't stand up anymore and I checked for a pulse. I couldn't find one and we yelled again for the nurses. V11 (LPN) ran for the crash cart and V14 (LPN) called for the ambulance and got his papers together. I waited with R3 laying on the floor and tried to get food out of his mouth until the crash cart came because we didn't know his code status and I didn't want to code him if he shouldn't be. I would say that we waited maybe 60 seconds for V11 (LPN) to get the cart. I was the first person to start CPR and then V8 (CNA) began to help me.</p> <p>On [DATE] at 1:05PM, V13 (PRSC) stated that CPR did not begin until V11 (LPN) returned to the dining room with the code cart.</p> <p>On [DATE] at 10:44AM, V17 (Nurse Practitioner) stated that CPR should be started immediately when a code occurs, and the code status is not known.</p>		

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<p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42702</p> <p>Based on interview and record review the facility failed to ensure that all nursing personnel were certified in cardiopulmonary resuscitation. This failure has the potential to affect all 86 residents who currently reside in the facility.</p> <p>Findings include:</p> <p>The facility census documents a census dated [DATE] documents a census of 86 residents.</p> <p>The facility provided Cardiopulmonary Resuscitation Policy dated [DATE] documents that nursing personnel of this facility shall be certified in cardiopulmonary resuscitation (CPR) within a reasonable time after hire but not to exceed 90 days.</p> <p>On [DATE] at 3:30PM, V2 (Registered Nurse) stated that they were working on a plan to have all staff CPR certified soon.</p> <p>On [DATE] at 11:46AM, V18 (Regional Clinical Nurse) provided some staff CPR cards but that they could not produce a CPR card for all nursing personnel of the facility.</p>