STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145584	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Mattoon	1000 Palm Mattoon, IL 61938

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to provide a safe transfer and thoroughly investigate a fall to identify root cause for one (R1) of three residents reviewed for falls in the sample list of six. Findings include: The facility's Fall Prevention policy dated 11/10/18 documents a fall huddle will be conducted with staff on duty immediately following a fall to help identify circumstances of the even and appropriate interventions, and circumstances of the fall will be documented in the nursing notes or on an Assess Intervene and Monitor for Wellness form. The facility's undated Transfer from Bed to Chair, Commode, or Wheelchair policy documents to use a gait belt and use a rocking technique to stand the resident. R1's Minimum Data Set, dated dated dated [DATE] documents R1 has moderate cognitive impairment and requires substantial/maximal staff assistance when moving from sitting to standing. R1's Care Plan dated 7/8/24 documents R1 has behaviors related to falls including being resistive to staff assisting him by stepping backwards, pulling away, and lowering himself to the floor. This care plan documents R1 requires moderate assistance of one staff person for chair/bed transfers and has not been updated with R1's 3/8/25 fall and post fall interventions. R1's Nursing Note dated 3/8/2025 at 4:44 AM documents an unidentified Certified Nursing Assistant (CNA) reported R1 had a staff assisted fall to the ground. There are no additional details regarding how the fall occurred documented in R1's medical record. R1's Incident Audit Report for R1's 3/8/25 fall documents information was obtained from R1's nursing notes and does not identify the staff involved in R1's staff assisted fall or if any devices were used during R1's transfer. This report documents and Interdisciplinary Team Review of Fall Note dated 4/8/25 at 11:27 AM that documents on 3/8/25 R1 had a staff assisted fall to the ground and the intervention was for staff to offer more assistance related to R1 needing more assistance with Activities of Daily Living. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/8/25 at 12:22 PM V35 (Registered Nurse) stated V35 works through an agency and night shift on 3/7/25 was the only day V35 has worked at the facility. V35 stated early morning on 3/8/25 an unidentified CNA came to report that she had assisted R1 to transfer from bed into a wheelchair and R1 fell . V35 stated it was documented that R1 was a one assist transfer at that time and based on what the CNA described it didn't sound like any assistive devices were used including a gait belt. V35 stated when V35 entered R1's room, R1 was lying on the floor with his head against the wall, R1 complained of back and neck pain and was transferred to the hospital. On 4/9/25 at 11:50 AM V17 (Quality Assurance/Licensed Practical Nurse) stated the CNAs should use a gait belt for all one to two assist transfers and gait belt usage would be documented as part of the fall investigation or on the risk management report. V17 stated V17 was unsure who the CNA was that assisted with R1's transfer/fall on 3/8/25 since V17 does not have witness statements for this fall. V17 stated V17 does the fall investigations but has been behind due to frequently being pulled to work the floor. At 11:58 AM V17 verified all fall documentation was provided regarding R1's 3/8/25 fall and confirmed there was no documentation that a gait belt was used during R1's transfer/fall. V17 stated if one was not used then that would change what was implemented as a post fall intervention, such as staff education.

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to timely report decreased urination and abdominal distention (R1). The facility also failed to perform hand hygiene after toileting assistance (R5) for two (R1, R5) of four residents reviewed for urinary tract infections (UTIs) in the sample list of six. This failure resulted in R1 being hospitalized for a UTI, urinary retention, and acute kidney injury. Findings include: 1.) R1's Minimum Data Set, dated dated dated [DATE] documents R1 has moderate cognitive impairment, is dependent on staff assistance for toileting, and is always incontinent of bowel and bladder. R1's Fluid Intake report dated March 2025 documents the following total daily fluid intake: 960 milliliters (ml) on 3/3/25 480 ml on 3/4/25 1100 ml on 3/5/25 360 ml on 3/6/25 1440 ml on 3/7/25 R1's Bowel and Bladder Elimination log dated March 2025 does not document R1 urinated on all shifts on 3/3/25, second shifts on 3/2/25, 3/6/25, 3/7/25 and third shifts on 3/1-3/5/25 and 3/7/25. This log documents R1 had a medium, loose bowel movement on 3/1/25, formed medium bowel movement on 3/4/25, loose medium bowel movements on 3/5/25-3/7/25 and one large loose bowel movement on 3/6/25. R1's Nursing Notes document the following: On 3/7/25 at 11:09 AM R1's abdomen was distended, and a new order was received to obtain a urinalysis. R1 had a loose medium bowel movement. On 3/7/25 at 7:46 PM R1's urine sample was collected and placed in the fridge for pick up. R1's urine was dark and odorous. On 3/7/25 at 9:11 PM R1's abdomen remained distended and firm. On 3/8/25 at 4:44 AM R1 fell during staff assist. R1 was lying on the floor complaining of back and neck pain and wanted to go to the emergency room . Emergency services was called. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	The healthcare messaging software documents on 3/6/25 at 2:30 PM R1 had abdominal distention, only one wet brief during the night and once during dayshift, took in 240 ml and had a loose bowel movement. This was reported to V33 (Advanced Practice Registered Nurse/APRN) who ordered a urine sample for urinalysis and culture with sensitivity. There is no documentation in R1's medical record that this order was transcribed until 3/7/25 at 4:33 AM, per R1's physician orders, or that R1 had abdominal distention prior to 3/7/25. There is no documentation that R1's abdominal distention and decreased urinary output was reported to V33 prior to 3/6/25 at 2:30 PM. R1's emergency room Note dated 3/8/25 at 6:17 AM documents a urinary catheter was inserted and with a return of over 2500 ml of urine. R1 was admitted with diagnoses of urinary retention, UTI, and acute kidney injury. R1's laboratory results dated [DATE] at 8:01 AM documents R1's Blood Urea Nitrogen (BUN) was 42 (high) and Creatinine (Cr) 1.57 (high). R1's Hospital Discharge Summary dated 3/12/25 documents a urinary catheter was inserted on admission with three liters of urine returned with initial gross hematuria (bloody urine) that resolved. R1's urine culture grew Enterococcus and R1 received antibiotic therapy. R1 was given intravenous fluids and R1's Creatinine levels normalized. Urology was consulted and ordered an abdominal Computed Tomography that showed a large amount of stool in the rectum with surrounding inflammatory changes consisted with stercoral proctitis (rare and serious inflammatory condition). R1 also had bladder wall thickening related to inflammatory changes, mild hydronephrosis, and gaseous bowel distention. Laxatives were ordered and R1 had several bowel movements during his hospitalization . The facility's Daily Assignment dated 3/5/25 documents V25 (Licensed Practical Nurse/LPN) was assigned to R1's unit for day shift and evening shift, V32 (Certified Nursing Assistant/CNA) was assigned R1's unit on day shift, and V24 (CNA) was assigned to R1's unit on evening shift. The Daily Assignments dated 3/6/25 and 3/7/25 document V24 was assigned to R1's unit on evening shift. On 4/7/25 at 1:29 PM V34 (APRN) stated V34 recently started working for the facility on 3/10/25. V34 stated R1 was hospitalized for urinary retention and UTI but had no prior history of UTIs or urinary retention. On 4/7/25 at 2:16 PM V13 (LPN) confirmed R1's abdomen was distended on 3/7/25. V13 stated there was already an order to collect R1's urine sample that was entered on the prior shift, and it was passed onto V13 that day that R1 had abdominal distention. V13 stated that day V13 had R1 urinate in a urinal, R1 put out almost a full urinal full of urine, and V13 collected R1's urine sample which was dark in color and cloudy. V13 stated unidentified staff had reported that R1 had difficulty urinating days prior. On 4/7/25 at 3:10 PM V24 (CNA) stated V24 went to get R1 up for supper one night, R1 was really sweaty and not acting himself, and R1 was sent to the hospital. V24 stated a week later R1 was sent to the hospital again (3/8/25) and returned to the facility with a urinary catheter. V24 stated during the week prior, R1 had been drinking well but R1's brief was dry most of the time which was unusual for R1 since R1 would usually pull his pants down and urinate a large amount all over. V24 stated V24 reported this to V25 (LPN). V24 stated R1's stomach looked more swollen on 3/7/25. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 4/8/25 at 9:46 AM V25 (LPN) stated R1 had no reported problems on 3/4/25. V25 confirmed on 3/5/25 V24 (CNA) reported R1 had not urinated that day. V25 stated R1's abdomen was also distended that day. V25 stated V25 just passed this information onto night shift and to monitor R1's urination. V25 confirmed V25 did not report R1's abdominal distention and decreased urine output to a physician or APRN. On 4/8/25 at 10:02 AM V32 (CNA) stated a few days prior to R1's hospitalization R1 wasn't himself, was urinating very little and did not have good bowel movements, which was new for R1. V32 stated R1 was still drinking well at that time, R1's abdomen started getting harder and bigger and V32 reported this to V25 (LPN). On 4/8/25 at 12:22 PM V35 (Registered Nurse/RN) stated V35 works through an agency, night shift on 3/7/25 was the only day that V35 had worked at the facility, and V35 was not very familiar with R1. V35 stated V35 sent R1 to the hospital early that morning following a staff assisted fall and complaints of back and neck pain. V35 stated nothing had been reported about R1 having decreased urination or abdominal distention. On 4/8/25 at 3:40 PM V2 (RN) stated V2 entered R1's urinalysis order on 3/7/25 which V2 obtained off the healthcare messaging software. V2 stated staff on the prior shift, second shift, had notified V33 (APRN) through the messaging software. On 4/8/25 at 1:15 PM V12 (Quality Assurance Nurse/Infection Preventionist) stated the CNAs should document continence/incontinence for urine output every shift. V12 verified the lack of this documentation from 3/1/25-3/7/25 on R1's bladder elimination log. V12 stated the CNAs should report decreased urine output to the nurse, the nurse should monitor for symptoms and notify the physician. V12 stated provider notification would be documented in a nursing note. At 2:15 PM V12 stated V36 (R1's Family) contacted V12 after R1's hospitalization to ask how the staff didn't notice R1's abdominal distention and decreased urine output. V12 confirmed R1's nursing notes do not document R1's decreased urine output and abdominal distention or that this was reported to a physician or APRN prior to 3/7/25. On 4/8/25 at 2:35 PM V33 (APRN) stated R1's abdominal distention and decreased urinary output should have been reported immediately. V33 stated a UTI can cause an obstruction in urinary flow and a UTI. V33 stated a delay in treatment of UTI and/or urinary retention can affect laboratory values, including elevated BUN and Cr, and cause an acute kidney injury. V33 stated V33 was assigned to receive calls for the facility between 9:00 AM and 5:00 PM Monday through Friday. V33 stated the on-call provider took call after 5:00 PM until 9:00 PM and outside of those hours the facility would have to contact the physician or medical director. The facility's Notification for Change in Resident Condition or Status policy dated 12/7/17 documents the charge nurse will notify the resident's attending physician or on-call physician when there are any signs or symptoms or apparent discomfort of sudden onset, a marked change, and unrelieved by previously prescribed measures; when there is a significant change in the resident's physical/emotional/mental condition; and when there is a need to significantly alter treatment. This policy documents that the nurse will document information related to the changes in a resident's condition in the resident's medical record. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	2.) On 4/9/25 at 11:37 AM V8 and V26 (CNAs) assisted R5 with toileting. V26 removed R5's soiled brief, applied a clean brief, and cleansed R5's perineal area. V26 removed her gloves and did not perform hand hygiene prior to leaving the room and transporting R5 in a wheelchair to the common area. On 4/9/25 at 11:48 AM V26 stated hand hygiene should be performed after providing toileting or incontinence cares. V26 confirmed V26 did not perform hand hygiene after providing R5's with toileting care. The facility's undated General Procedure for Toileting policy documents to wash your hands after providing toileting assistance and perineal care.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50322 Based on observation, interview and record review, the facility failed to ensure there is a sufficient number of certified nursing assistants to provide care and respond to resident's basic individual needs. This failure has the potential to affect all 82 residents currently residing at facility. Findings include: Facility census dated 4/7/25 documents 82 residents in house, 29 residents on southwest hall (100's rooms), 23 residents on [NAME] East (500's rooms), and 30 residents on [NAME] (600's rooms). Facility assessment tool with documented updated date of 8/4/24 documents the facility has an average of 80-85 residents daily. Documents that capacity to manage oxygen therapy as well as CPAP and BIPAP, also documents on average the facility has 68 residents needed at minimum one person to 2 person assist, while about 20 are totally dependent on staff assistance for activities of daily living. 17 residents require assistance with ambulation while 45 residents are in some type of medical chair. More than half of the residents require some form of behavioral health management. Facility documents staffing at total number needed daily to accommodate all residents needs as 8 licensed nursing staff, 16 nurse aides, 4 other nursing administrative staff, 9 additional (not listed) staff for behavioral healthcare services, 2 dieticians, 5 food services staff and zero respiratory care staff. The following dates were audited for certified nursing assistants (CNA) staffing numbers for the night shift of 10:00pm thru 6:00am: 4/2/25, 4/4/25, 4/5/25, and 4/6/25. Facility CNA schedule for the month of April reviewed; the daily assignment sheets, and timecards for CNAs listed on daily assignment sheets night shift. Daily assignment sheet dated 4/2/25 documents 2 CNAs and one unit aide (UA) working Southwest (SW) hallway and 2 CNAs and one UA working both halls of [NAME] Unit. Timecard audit revealed from 10:00pm-6:00am V41 (CNA) was on SW with V40 (UA) in after Midnight. On [NAME] Unit there was V4 (CNA) and no UA until 4:00am when the shower CNA V38, clocked in resulting in a ratio of 1:53. On 4/4/25 V41 and V52 (CNAs) and V40 (UA) on SW; V29 & V23 (CNAs) with V39 (UA) on [NAME] on assignment, timecards show that V23 and V52 (CNAs) clocked out at 2:00am leaving one CNA (V5) on SW and one CNA (V41) on [NAME], V40 (UA) on SW arrived after midnight and V39 (UA) on [NAME] clocked out at 4:00am. V4 (CNA) clocked in at 4:30am. Daily assignment for 4/5/25 documents V5 & V53 (CNAs) with V40 (UA) on SW, and V4 & V23 (CNAs) on [NAME]. Actual time shows V5 and V53 worked 10:00pm-6:00am on SW with V40 (UA) in after midnight, and V23 (CNA) on [NAME] from 10:00pm to 2:00 am at which time she clocked out leaving 1 LPN and no other staff for 53 residents on locked behavior unit. 4/6/25 daily documents V5 and V6 (CNA) on SW and V4 & V23 (CNAs) on [NAME] until 2:00am leaving V4 (CNA) and V39 (UA) until V39 leaves at 4:00am. Timecards confirm daily schedule is accurate. Observation of all staff on property at 5:15am confirms. On 4/7/25 at 5:00 am there was only V4 (CNA) on [NAME] wing. On 4/7/25 at 5:01 V2 (Registered Nurse/RN) standing at med cart mid-hall. V2 states that there is himself, 1 Licensed Practical Nurse/LPN, and 3 CNAs currently working. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/7/25 at 5:58 am V3 (LPN) at 600 hall nursing station. V3 stated she works for agency. V3 confirms she was the nurse for the entire psych unit with one CNA throughout the night. Denies any issues. V7 (LPN) entered nursing desk area at this time stating she's unclear if she's supposed to be here because there is no staffing assignment posted but she is on the master schedule. On 4/7/25 at 6:04 am V8 (CNA) states there was only one CNA (V4) overnight and that she was waiting to get report but states usually there are 3 CNAs for the unit during the day and one nurse for each hall on locked unit. On 4/7/25 at 6:15 am V9 (LPN) states currently there is herself and 3 CNAs on hall with an additional CNA scheduled at 8:00 am. On 4/8/25 at 10:15 AM R5 stated they don't have enough CNAs; the CNAs must go back and forth between the halls. On 4/8/25 at 10:16 AM V7 (LPN) stated night shift usually has one nurse and one to two Certified Nursing Assistants (CNAs) for [NAME] unit. It depends on how the night went, if it was a busy night then we have had concerns with incontinence cares not being done timely. On 4/8/25 at 10:35 AM V8 (CNA) stated the agency staff don't always show up for work and the facility does not always find a replacement or coverage. V8 stated the night shift staffing is bad and the facility usually only has one CNA assigned to [NAME] unit. V8 stated incontinence cares are affected by this and V8 must catch up on incontinence cares when V8 comes into work at 6:00 AM. On 4/8/25 at 12:22 PM V35 (RN)e stated V35 is an agency nurse and night shift on 3/7/25 was her first and only time she worked at the facility. V35 stated the facility is short staffed, V35 was the only nurse assigned to two halls and 30 residents that night with two CNAs. V35 stated that is not enough staff for the [NAME] unit and makes it difficult to supervise and account for the residents on that unit who have behaviors and/or who wander. On 4/8/25 between 2:55 PM and 3:25 PM V22, V23, and V24 (CNAs) were the only CNAs working on Willow. At 3:10 PM V24 stated V24 is the only CNA currently working the East wing of Willow. V24 stated one CNA is not enough for this wing due to resident behaviors and wandering residents who need to be watched closely. On 4/9/25 at 9:00am, V14 (Human Resource Director) states she has been the facility clinical scheduler for [AGE] years. V14 states they use agency to supplement nurses and certified nurse assistants (CNA) for staffing needs. V14 Confirms that currently the facility has 2-unit aides, and 32 CNAs. V14 states that all agency staff must have signature and photo verification in facility for payment, so they can't clock in and leave facility. When V14 is notified of a call off or no show, she immediately attempts to find a replacement. States she does not have a guideline or formula she follows when scheduling staff, she just knows what is needed. For CNAs there should be 4 on Southwest (SW), 2 on [NAME] (WW) and 2 on [NAME] East (WE) for both day and evening shifts and 2 on SW, 1 on WW and 1on WE with unit aides to help. V14 states she's unclear why there was only one CNA on the willow's unit overnight 4/6/25, but states sometimes she isn't called when staff doesn't show. Reviewed clinical schedules for months of March and April, reviewed daily assignment sheets, and reviewed all timecards provided for accuracy. V14 confirms all documents are correct.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50322 Based on interview and record review, the facility failed to ensure there is a full time Director of Nursing (this was corrected during the survey). Facility also failed to ensure a Registered Nurse (RN) is providing services to residents at least 8 consecutive hours a day, 7 days a week. This failure has the potential to affect all 82 residents currently residing at facility. Findings include: Facility census dated 4/7/25 documents 82 residents in house, 29 residents on southwest hall (100's rooms), 23 residents on [NAME] East (500's rooms), and 30 residents on [NAME] (600's rooms). Facility assessment tool with documented updated date of 8/4/24 documents the facility has an average of 80-85 residents daily. Documents that capacity to manage oxygen therapy as well as CPAP and BIPAP, also documents on average the facility has 68 residents needed at minimum one person to 2 person assist, while about 20 are totally dependent on staff assistance for activities of daily living. 17 residents require assistance with ambulation while 45 residents are in some type of medical chair. More than half of the residents require some form of behavioral health management. Facility documents staffing at total number needed daily to accommodate all residents needs as 8 licensed nursing staff, 16 nurse aides, 4 other nursing administrative staff, 9 additional (not listed) staff for behavioral healthcare services, 2 dieticians, 5 food services staff and zero respiratory care staff. The following dates were audited for RN coverage and sufficient nursing staff: 3/14/25, 3/18/25, 3/21/25 and 3/28/25. Facility nursing schedule for the month of March reviewed, the daily assignment sheets, and timecards for nurses listed on daily assignment sheets. For all 4 dates audited, there was no RN coverage for a period of 24 hours or greater. Multiple discrepancies were found. Actual worked hours by staff revealed the following: On 3/14/25 the facility ran 1 nurse short from 6:00am thru 12:50pm and 6:20pm-10:00pm. On 3/18/25 ran 1 nurse short from 6:00am thru 12:00pm. On 3/21/25 one day shift Licensed practical nurse/LPN, V7, listed had no timecard for that day. No other nurse is listed as back up, V17 who was not listed on daily assignment, timecard stamped 7:37am in and 3:17pm out. On 3/28/25 the facility ran one nurse short from 6:56pm-10:00pm. On 4/8/25 at 9:46 AM V25 (LPN) states with 22-24 residents I do have to assist with cares. It doesn't seem enough. We have mechanical lifts that require 2 assists. Last Wednesday it was only me to cover both halls back here. I was still able to get meds done and treatment done. No falls or major issues. The agency staff are sometimes listed on the schedules and then don't show up. On 4/8/25 at 3:30pm, V1 (Administrator) states that she has not had a Director of Nursing for a long time. States the regional consulting nurse was in facility daily end of February and first week of March while V1 was on vacation. V1 states she hired a DON who started 4/7/25, but again confirms there was no in-house DON for month of March. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/9/25 at 9:00am, V14 (Human Resource Director) states she has been the facility clinical scheduler for [AGE] years. V14 states they use shift key agency to supplement nurses and certified nurse assistants (CNA) for staffing needs. Confirms that currently the facility has 7 full time and 1 PRN LPNs, 1 staff RN and 1 full time and 1 PRN RN managers that do not work the floor. Agency nurses are LPNs. States Director of Nursing started 4/7/25 but none for months prior. V14 states that their one full time RN works every night shift 10p-6a except Fridays. For nurses she has V17 (LPN) that will fill in. V14 states that she schedules for 3 nurses for day and evening and 2 nurses night shift. Reviewed clinical schedules for months of March and April, reviewed daily assignment sheets, and reviewed all timecards provided for accuracy. V14 confirms all documents are correct.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145584	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Garden of Mattoon	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)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to ensure appropriate prescribing of antibiotics for one (R4) of four residents reviewed for urinary tract infections (UTIs) in the sample list of six. Findings include: The (official name of publisher) Educational Module for Nurses in Long-term care Facilities: Antibiotic Use and Antibiotic Resistance dated December 2014, provided by the facility on 4/8/25 as their policy, documents an example of antibiotic misuse as using broad-spectrum antibiotics when laboratory results indicate that a narrow-spectrum antibiotic would be effective. The facility's Resident Infection Control and Antimicrobial Log dated March 2025 documents R4 was prescribed Bactrim Double Strength (DS) 800-160 milligrams twice daily for 10 days from 2/27/25 through 3/9/25. This log documents microbiology results as mixed flora and criteria not met for clinical documentation to support antibiotic use and prescribing antibiotics for bacteria in the urine without the presence of clinical symptoms. This module documents to obtain microbiology cultures prior to initiating treatment and cultures and sensitivity tests should be used to guide appropriate prescribing of antibiotics. R4's Physician order with start date 12/26/24 and stop date 3/10/25 documents R4 has a urinary catheter related to urinary retention. R4's Nursing Notes document the following: On 2/10/25 at 2:53 AM R4 continues on isolation for Methicillin Resistant Staphylococcus Aureus (MRSA), a multidrug resistant organism, catheter associated UTI. On 2/27/2025 at 5:15 PM R4 was prescribed Bactrim DS by mouth twice daily for 10 days for UTI. On 2/27/2025 at 2:53 PM R4 was placed on contact isolation pending urinalysis and culture with sensitivity if indicated. On 3/3/2025 at 9:41 AM V33 (Advanced Practice Registered Nurse/APRN) was notified that urine culture was not obtained, and V33 gave orders to continue with the current treatment if already initiated. On 3/8/2025 at 2:20 PM R4 was lethargic and only had 50 milliliters or urine output. R4 was transferred to the hospital. R4's Urinalysis dated 2/24/25 documents positive for nitrites, 4+ leukocytes and trace bacteria, abnormal results. The final culture showed mixed flora with multiple species present and recommends repeating specimen collection if indicated. A sensitivity report was not completed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There is no documentation of R4's symptoms that prompted R4's urinalysis and antibiotic treatment and that another urine specimen was collected prior to R4 being hospitalized on [DATE]. R4's urine culture dated 3/10/25 documents R4's urine contained greater than 100,000 colony forming units per milliliter of MRSA. On 4/8/25 at 11:40 AM V12 (Quality Assurance Nurse/Infection Preventionist) provided R4's urine cultures. V12 reviewed R4's 2/24/25 urinalysis results and confirmed it documented mixed growth and recommended to obtain another specimen. V12 stated another culture wasn't done, R4's UTI was treated based on what is recorded on the infection control log and criteria was not met for appropriate antibiotic use. V12 confirmed R4 did not have documented symptoms of UTI prior to antibiotics being ordered on 2/27/25 and a repeat culture should have been done to determine bacteria and if susceptible to the antibiotic ordered. On 4/7/25 at 1:29 PM V34 (APRN) stated antibiotics for UTIs should not be initiated until after urine culture results are received.