

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  08/06/2025
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)
F 0580  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.  (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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review the facility failed to notify one (R1) residents court appointed Guardian of changes in medications and laboratory orders out of three residents reviewed for notifications in a sample list of four residents. Findings Include:R1's Electronic Medical Record (EMR) documents R1's primary diagnosis is the medical management of Paranoid Schizophrenia. Other medical diagnoses include Thyrotoxicosis, Noncompliance with medication regimen, Cannabis abuse with Psychotic Disorder with Hallucinations, Major Depressive Disorder, Anxiety and Insomnia.R1's Letters of Office-Guardianship filed 11/18/2024 documents R1 as a 'Disabled Adult' and that V4 has been appointed R1's Court Appointed Guardian. This same letter documents V4 has access to the psychological and psychiatric treatment for the benefit of R1, consent to or withdraw the administration of psychological and psychiatric, psychotropic medications for the benefit of R1, consent to or refuse any treatment on behalf of R1 for any physical, mental, or emotional illness, consent to and facilitate therapy and counseling services for the benefit of R1 and to take all actions and make all decisions necessary or incidental to the specific authority granted above. R1's Physician Order Set (POS) dated August 2025 documents a physician order starting 11/25/24 for Thyroid Stimulating Hormone (TSH), Free T3 and Free T4 to be drawn monthly. This same POS documents a physician order starting 2/19/25 for R1's TSH, Free T3 and Free T4 to be drawn every three months. This same POS physician orders starting 4/7/25 for Ativan 0.5 milligrams (mg) twice daily for Anxiety. R1's Ativan was changed from an as needed basis to a scheduled dose on 4/7/25. R1's Electronic Medical Record (EMR) does not document V4 (R1's) court appointed Guardian as being notified of R1's psychotropic medication changes nor R1's changes in scheduled lab work.On 8/5/25 at 1:50 PM V4 (R1's Court Appointed Guardian) stated V4 has informed the facility shortly after R1's admission to the facility that V4 is the court appointed guardian and needs to be notified of all changes for R1. V4 stated the facility does not notify her of any medication/behavioral changes with R1. V4 stated R1 was diagnosed with Hyperthyroidism and was supposed to be having lab work done every week prior to her admission to the facility which should have continued through R1's stay. V4 stated if a Physician has changed that order, V4 was never made aware. On 8/5/25 at 3:15 PM V12 (Psychiatric Rehabilitation Services Director/PRSD) stated there is no documentation to show that V4 (R1's Court Appointed Guardian) has been notified of R1's psychotropic medication changes and laboratory order results/changes. V12 stated she spoke with V4 on 7/24/25 during R1's care plan. V12 stated V4 reported R1 has not been receiving her psychotropic medications timely. V12 stated she did not have any answers for V4 at that time but could see in R1's Medication Administration Record (MAR) that R1 had missed several doses of her Ativan. V12 stated she let V2 (Director of Nursing/DON) know of V4's concerns since they are considered clinical concerns. On 8/6/25 at 9:30 AM V2 (DON) stated the facility should have notified V4 (R1's Guardian) of any changes in R1's lab orders, lab results and any medication changes. V2 stated the facility does not have any documentation to provide that V4 was notified. The facility policy titled Notification of Change in Resident Condition or Status reviewed May 2025 documents the nurse supervisor/charge nurse will notify the Director of Nurses (DON), Physician and unless otherwise instructed by the resident, the resident representative or next of kin when there is a need to alter the resident's medical treatment significantly. Except in medical emergencies, notifications will be made within 24 hours of a change occurring in the resident's medical/mental condition or status.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>Based on observation, interview and record review the facility failed to administer one (R1) resident's psychotropic medication per physician order causing R1 to miss ten doses. This failure affected one (R1) out of three residents reviewed in a sample list of four residents. Findings Include:R1's Electronic Medical Record (EMR) documents R1's primary diagnosis is the medical management of Paranoid Schizophrenia. Other medical diagnoses include Thyrotoxicosis, Noncompliance with medication regimen, Cannabis abuse with Psychotic Disorder with Hallucinations, Major Depressive Disorder, Anxiety and Insomnia.R1's Physician Order Set (POS) dated August 2025 documents a physician order starting 4/7/25 for Ativan 0.5 milligrams (mg) twice daily for Anxiety.R1's Pharmacy packing slip dated 6/8/25 documents 30 tablets of Ativan 0.5 milligrams (mg) were delivered to the facility on 6/8/25.R1's Medication Administration Record (MAR) dated June 2025 documents R1 was not administered her physician ordered Ativan 0.5 mg on the mornings of 6/7/25, 6/23/25 and on the evenings of 6/6/25, 6/7/25, 6/19/25, 6/22/25, and 6/23/25. R1's MAR dated July 2025 documents R1 was not administered her Ativan 0.5 mg the morning of 7/10/25 and the evenings of 7/9/25 and 7/10/25. On 8/5/25 at 4:00 PM the facility back medication storage system is in a locked room in the middle section of the facility. On 8/6/25 at 2:00 PM V2 (Director of Nurses/DON) stated there were issues with obtaining a renewal prescription from the physician. V2 stated the facility should have ensured the physician was notified timely prior to R1 running out of her Ativan. V2 stated nursing staff are aware that prescriptions of Ativan require a physician signature for a renewed prescription and then notification to the pharmacy. V2 stated R1 should never run out of her Ativan due to a delay caused by the facility. The facility policy titled Medication Administration reviewed April 2025 documents if the medication is not available for the resident, call the pharmacy and notify the Physician when the drug is expected to be available. Notify the Physician as soon as practical when a scheduled dose of medication has not been administered for any reason. Report errors in medication administration immediately per policy.</p>		