

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 09/24/2025
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview, and record review, the facility failed to obtain physician orders for oxygen therapy (R4), failed to administer oxygen according to physician orders (R11), and failed to change oxygen humidifier bottles and tubing according to physician orders (R4 and R11). These failures affect two residents (R4 and R11) out of five reviewed for specialized services on a sample of eleven. Findings include: 1) R4's medical diagnoses list dated 9/24/25 documents R4 experiences medical conditions including Chronic Obstructive Pulmonary Disease, Chronic Respiratory Failure with Hypoxia, Respiratory Conditions due to Unspecified External Agent, Chronic Congestive Heart Failure, and Unstable Chest Pain. On 9/23/25 at 10:04 AM, R4 was seated in a recliner in his room receiving oxygen therapy through a nasal cannula tubing from an oxygen concentrator running at two and one half liters per minute. R4's oxygen humidifier bottle was completely dry. R4's nasal cannula and humidifier bottle were dated 9/1 (2025). On 9/23/25 at 10:04 AM, R4 stated his oxygen should be running around 4 liters per minute. R4 acknowledged his oxygen humidifier bottle was dry and stated it happens frequently. On 9/24/25 at 1:25 PM, R4 was seated in a recliner in his room, again receiving oxygen therapy through a nasal cannula tubing from an oxygen concentrator running at two and one half liters per minute. R4 stated no one had come to give him a new oxygen humidifier bottle yet. R4's current physician order sheet dated 9/24/25 did not include any physician orders for oxygen therapy, the rate at which R4 was to receive oxygen, nor the delivery method such as from a mask versus the nasal cannula tubing. This same physician order sheet did document R4's oxygen humidifier bottle and nasal cannula tubing were to be changed weekly every Sunday night. On 9/24/25 at 1:35 PM, V2 (Director of Nursing) stated R4's oxygen humidifier bottle and nasal cannula tubing were supposed to be changed every Sunday night. 2) R11's medical diagnoses list dated 9/24/25 documents R11 experiences medical conditions including Emphysema, Sleep Apnea, and Solitary Pulmonary Nodule. On 9/24/25 at 1:48 PM, R11 was seated in a chair in his room receiving oxygen through a nasal cannula tubing from an oxygen concentrator running at five liters per minute. R11's oxygen humidifier bottle had approximately one eighth of an inch of water which was low enough that the oxygen supply was not touching the water to create any bubbles. R11's oxygen humidifier bottle and nasal cannula tubing were not dated to indicate the most recent time they were changed. R11's current physician order sheet dated 9/24/25 documents R11 is to receive oxygen therapy at two liters per minute at night and during naps, and at two liters per minute as needed during the daytime. This same physician order sheet documents R11's oxygen humidifier bottle and nasal cannula tubing are to be changed weekly on Tuesday nights (the most recent of which would have been 9/23/25). On 9/24/25 at 3:09 PM, V2 (Director of Nursing) stated R11's humidifier bottle would not have run down to the level of one eighth of an inch if it was changed according to the physician orders the night before on 9/23/25. The facility's policy Oxygen Administration dated as revised October 2010, provided by V15, Regional Nursing Consultant, documents the first step in administering oxygen to a resident is to verify there is a physician's order. This policy documents a humidifier bottle is necessary equipment for administering oxygen. This policy further documents to adjust the oxygen delivery equipment so the proper flow of oxygen is being administered. This policy documents to check the humidifying jar to be sure there is water in the jar and the water level is high enough that the water bubbles as the oxygen flows through. This policy documents nursing staff are to check the water level periodically.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on observation, interview, and record review, the facility failed to accurately record provided services by documenting incomplete treatments as completed. This failure affects two residents (R4 and R11) out of five reviewed for specialty services and treatments on the sample list of eleven. Findings include: 1) On 9/23/25 at 10:04 AM, R4 was seated in a recliner in his room receiving oxygen therapy through a nasal cannula tubing from an oxygen concentrator running at two and one half liters per minute. R4's oxygen humidifier bottle and nasal cannula tubing were both dated 9/1 (2025) to indicate the last time they were changed. R4's oxygen humidifier bottle was completely dry. R4's current Physician Order Sheet dated 9/24/25 documents R4's oxygen humidifier bottle and nasal cannula tubing need to be changed weekly on Sunday nights. R4's Treatment Administration Record for September, printed on 9/24/25, includes nursing staff initials and a checkmark on each of the scheduled dates when R4's oxygen humidifier bottle and nasal cannula tubing was scheduled to be changed, 9/7, 9/14, and 9/21. 2) On 9/24/25 at 1:48 PM R11 was seated in a chair in his room receiving oxygen therapy through a nasal cannula tubing from an oxygen concentrator. R11's oxygen humidifier bottle and nasal cannula tubing were not dated to indicate the last time they were changed. R11's current Physician Order Sheet dated 9/24/25 documents R11's oxygen humidifier bottle and nasal cannula tubing need to be changed weekly on Tuesday nights. R11's Treatment Administration Record for September, printed 9/24/25, includes nursing staff initials and checkmarks on each of the dates R11's oxygen humidifier bottle and nasal cannula tubing was scheduled to be changed, 9/2, 9/9, 9/16, and 9/23. On 9/24/25 at 1:35 PM, V2 (Director of Nursing) confirmed the nurses' initials and checkmarks are placed on the record to indicate the humidifier bottle and nasal cannula tubing had been changed in accordance with the physician orders but obviously had not been changed. V2 further stated the nurses' initials were from agency nurses and not facility staff nurses, but she would need to educate all the nurses, including agency nurses, about accurate documentation. V2 confirmed R4's oxygen humidifier bottle would not run dry in two days, nor R11's run down to one eighth of an inch overnight, if they had been changed as documented by the agency nurses. The facility policy Oxygen Administration dated as revised October 2010, provided by V15, Regional Nurse Consultant, documents information that should be recorded in the resident's medical records including the date and time of procedures, the nurses' name and title who performed the procedure, and needs to be documented or recorded in accordance with professional standards of practice. The facility policy Charting and Documentation dated as revised July 2017 documents all treatments and services provided to the resident shall be documented in the resident's medical record. This policy further documents that all documentation will be complete and accurate.</p>		