STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145945	A. Building B. Wing	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Imboden Creek Senior Living	180 West Imboden Decatur, IL 62521

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42702 Based on interview and record review, the facility failed to provide an accurate Advanced Directive for one (R5) of three residents reviewed for Advanced Directives from a total sample list of 16 residents. Findings Include: The facility provided Advanced Directives Policy, dated [DATE], documents that upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if her or she chooses to do so. Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family members and /or his or her legal representative, about the existence of any written advance directives. The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive. The Director of Nursing Services or designee will notify the Attending Physician of advance directives so that appropriate orders can be documented in the resident's medical record and plan of care. R5's Physician Orders for Life-Sustaining Treatment (POLST), dated [DATE], documents R5 wishes to have cardiopulmonary resuscitation attempted with selective treatment. R5's progress notes, dated [DATE], document R5 was discharged to the hospital. R5's progress notes, dated [DATE], document R5 was readmitted to the facility on hospice care. R5's progress notes, dated [DATE], documents R5 was confirmed expired at 12:06PM, with no attempt at cardiopulmonary resuscitation for R5. R5's POLST form, dated [DATE], remains the only Advanced Directive in R5's medical record until her death dated [DATE]. On [DATE] at 12:42PM, V2, Director of Nursing (DON), stated when R5 readmitted from the hospital, the facility did not obtain a new POLST indicating R5 had chosen not to have cardiopulmonary resuscitation or extraordinary measures upon death. V2, DON, stated they should have gotten a new order for a DNR status per their policy.

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