STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145584	A. BUILDING _____ B. WING _____	**08/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PALM TERRACE 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 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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to notify the physician that a medication was not administered per physician's order for one of three residents (R6) reviewed for antipsychotic medication the sample list of nine. Findings include: R6's Medication Administration Record [REDACTED]. This Medication Administration Record [REDACTED]. R6's medical record does not document that the physician was notified that the medication was not given on 3/26/20. On 8/20/20 at 8:24 AM, V23 Licensed Practical Nurse stated R6 was readmitted to the facility on [DATE]. R6 was admitted with an order for [REDACTED]. On 8/20/20 at 11:20 AM, V1 Administrator stated the physician was not notified that R6's [MEDICATION NAME] was not given on 3/26/20. The Facility's Medication Administration policy dated 11/18/17 documents, 22. Notify the physician as soon as practical when a scheduled dose of a medication has not been administered for any reason.
F 0689 **Level of harm** - 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** Based on observation, interview, and record review the facility failed to provide a safe environment by failing to accurately determine the need for padded side rails, failing to provide safe transfers, and failing to apply a seatbelt utilized for safety for one of three residents (R1) reviewed for injury of unknown origin on the sample list of nine. These failures resulted in R1 sustaining a right elbow fracture. Findings include: R1's Radiology report dated 8/9/20 documents R1 has a complete oblique fracture involving the olecranon to the right elbow. R1's emergency room report dated 8/9/20 documents: R1 was sent to the emergency room for a broken elbow. R1's right elbow was bruised and swollen. R1 is bedridden or wheelchair bound at all times. The fracture is an olecranon fracture. R1's emergency room paperwork contained an informational document that documents an Olecranon fracture commonly occurs after falling on a hard surface with a bent elbow and other causes include a forceful hit (blow) to the elbow, falling onto an outstretched arm, or a forceful twist to the elbow. On 8/18/20 at 4:15 PM, V5 Registered Nurse stated R1 is immobile and requires staff assistance to get out of bed. V5 stated R1 can not turn self in bed and has side rails on both sides of the bed. V5 stated R1 is dependant on staff to move from the bed to chair. V5 stated R1 is transferred with a mechanical lift. V5 stated R1 can not move self in wheelchair and has to be pushed. The facility's final report dated 8/9/20, written by V2 Unit Director/Registered Nurse documents that R1 relies on staff for transfers using a mechanical lift and uses a wheelchair for locomotion per staff. This report document R1 was sent to the emergency roiagnom on [DATE] for swelling to the right elbow and that R1 was diagnosed with [REDACTED]. This report documents a conclusion that the facility was unable to determine the cause of the fracture. This report documents R1 as having a history of [MEDICAL CONDITION] which may have caused the injury. On 8/17/20 at 11:27 AM, V2 Registered Nurse/Unit Director stated V2 investigated R1's fracture. V2 stated R1 has bilateral half rails that are put up when R1 is in bed. V2 stated during the investigation of R1's injury of unknown injury V2 noted that the rails were not padded. V2 stated V2 discovered V3 CNA (Certified Nursing Assistant) had transferred R1 on 8/8/20 on the second shift. V3 stated V3 transferred R1 by cradle lifting by V3's self instead of using the mechanical lift. R1 is a mechanical lift. V2 stated V3 received a written discipline for transferring R1 incorrectly. V2 stated R1 can not bear weight or turn self in the bed. V2 stated R1 wears a seatbelt when up in the wheelchair due to sliding in wheel chair. On 8/17/20 at 11:41 AM, half side rails were elevated on both side of R1's bed. R1's physician's orders [REDACTED]. On 8/19/20 at 7:12 AM, V17 Licensed Practical Nurse stated R1 is extensive assist with bed mobility. V17 stated R1 has a [MEDICAL CONDITION] disorder and has had [MEDICAL CONDITION] in the past. V17 stated R1 had a [MEDICAL CONDITION] around the beginning of July. R1's side rail assessment dated [DATE], 5/5/20, and 8/11/20 does not document that R1 has a [MEDICAL CONDITION] disorder under the assessment of considerations for entrapment. This assessment documents if a [MEDICAL CONDITION] disorder is present the facility needs to consider padding side rails. On 8/19/20 at 10:34 AM, V7 Care Plan Coordinator stated V7 stated that she should have marked yes on the side rail assessment. V7 stated R1 side rails should have been padded due to R1 having a [MEDICAL CONDITION] disorder. On 8/19/20 at 7:22 AM, V16 CNA stated R1 can not move in bed at all. R1 would not be able to try to stand up, R1 doesn't even try to move in R1's wheelchair, the most R1 can do is move R1's arms a little bit. R1's rail was not padded before R1's elbow fracture. V16 stated V16 thinks R1 was injured when they rolled R1 in bed or laid R1 down it may have hit the bed rail. V16 stated R1 is a mechanical lift but they (the staff) had been cradle lifting R1 before R1 got the fracture. V16 stated R1 was supposed to be a mechanical lift. R1's care plan dated 5/18/16 documents an intervention to use two assist with the mechanical lift for all transfers. On 8/18/20 at 3:34 PM, V3 CNA stated she took care of R1 on 8/8/20 on the second shift. V3 stated R1's side rails were not padded at the time. V3 stated she cradle lifted R1. V3 stated everyone lifts R1 like that. V3 stated V3 knew R1 was a mechanical lift. R1's Physician order [REDACTED]. On 8/17/20 at 11:41 AM, R1 was sitting up in a high back wheel chair and was covered with a blanket. R1's safety belt was not in place. V9 (certified nursing assistant) CNA in training and V16 CNA were present in the room. V16 stated they did not fasten R1's safety belt. On 8/26/20 at 9:06 AM, V2 Registered Nurse/Unit Director there isn't a way that R1 could have injured R1's self. V2 stated R1's side rails were not padded prior to R1 having a fractured elbow. V2 stated the facility did discipline V3 for not using the mechanical lift.
F 0700 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to accurately assess entrapment risk for one of three residents (R1) reviewed for injury of unknown origin on the sample list of nine. Findings include: On 8/17/20 at 11:41 AM, half side rails were elevated on both side of R1's bed. R1's physician's orders [REDACTED]. R1's side rail assessment dated [DATE], 5/5/20, and 8/11/20 does not document that R1 has a [MEDICAL CONDITION] disorder under the assessment of considerations for entrapment. On 8/19/20 at 10:34 AM, V7 Care Plan Coordinator stated V7 stated that she

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0700 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) should have marked yes on the side rail assessment.
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.** Based on observation, interview, and record review the facility failed to employee a full time Director of Nursing. This failure has the potential to affect all 102 residents residing in the facility. Finding include: On 8/17/20 from 10:00 AM to 2:00 PM there was not a Director of Nursing working in the facility. On 8/17/20 at 10:20 AM, V8 Assistant Administrator stated there is not a Director of Nursing employed by the facility. On 8/17/20 at 11:02 AM, V1 Administrator stated there is not a Director of Nursing employed by the facility. The facility's undated resident listing provided by V1 Administrator documents there are 102 residents residing in the facility. On 8/26/20 at 2:41 PM, V1 Administrator stated there are 102 residents residing in the facility. V1 stated the last time the facility had a Director of Nursing was 2/12/2020.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to act upon a pharmacy notification that a [MEDICAL CONDITION] medication was unavailable from the pharmacy for one of three residents (R6) reviewed for [MEDICAL CONDITION] medications on the sample list of 9. Findings include: R6's physician's orders [REDACTED]. On 8/20/20 at 10:26 AM, V24 Pharmacist stated the facility sent the order for the [MEDICATION NAME] 117 milligrams on 3/9/20. V24 stated the pharmacy faxed the facility to let them know that it wasn't covered by the insurance on 3/09/20 because of being over the dollar amount allotted. V24 stated the facility did not contact them until the facility sent a request on 4/7/20 to fill the medication and then we sent a fax back saying the medication was not covered. R6's medical record does not contain documentation that the pharmacy was contacted by the facility until 4/7/20. On 8/20/20 at 11:20 AM, V1 Administrator stated there is no documentation that the facility attempted to contact the pharmacy until 4/7/20. The facility's Medication Administration Policy documents, 21. If the medication is not available for the resident call the pharmacy and notify the physician when the drug is expected to be available.
F 0760 **Level of harm** - Actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide a [MEDICAL CONDITION] medication per physician's order for one of three residents (R6) reviewed for [MEDICAL CONDITION] medications on the sample list of nine. This failure resulted in R6 having a psychotic episode which required hospitalization and electroconvulsive treatment. Findings include: R6's Behavioral Health Discharge note written by V26 Psychiatrist dated 4/21/20 documents, (R6) was discharged to (the facility) on 3/9/20. After discharge, (R6's) [MEDICATION NAME] injection due date was apparently overlooked by nursing staff. By the time the due date was discovered and the medication was ordered by the pharmacy, the pharmacy informed the facility that the medication was not covered by the (R6's) insurance. According to (V25, Registered Nurse) at (the facility), (R6) began spitting out (R6's) psychiatric medications and posturing on 4/6/20. On 4/8/20, (R6) refused to leave (R6's) clothing on and became physically aggressive with the nursing home staff. (R6) was transported to (the hospital) for further evaluation and treatment. (R6) required restraints as (R6) was combative with paramedics. In the emergency department, (R6) refused to answer questions. (R6's) medical work-up was reassuring. (R6) was subsequently transferred to psychiatry for further evaluation and treatment. R6's Medication Administration Record [REDACTED]. This Medication Administration Record [REDACTED]. On 8/20/20 at 8:24 AM, V23 Licensed Practical Nurse stated R6 was readmitted to the facility on [DATE], R6 was admitted with an order for [REDACTED]. R6 went to the hospital 4/8/20 due to refusing R6's medications and psychiatric issues. R6's Behavioral Health Discharge note written by V26 Psychiatrist dated 4/21/20 documents R6 had a total of three electroconvulsive therapy treatments while R6 was here in the hospital. On 8/24/20 at 8:34 AM, V26 Psychiatrist stated R6 was a harm to himself and others when admitted to the hospital on [DATE]. V26 stated R6's psychotic episode was due to not receiving the prescribed [MEDICATION NAME]. V26 stated R6 required electroconvulsive therapy while in the hospital.
F 0839 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Employ staff that are licensed, certified, or registered in accordance with state laws.** Based on interview and record review the facility failed to ensure a licensed nurse administered medications to 28 residents of 28 residents (R2, R9, R10 through R35) reviewed for medication administration on the sample list of 35. Findings include: On 8/26/20 at 10:59 AM, V30 Licensed Practical Nurse (LPN) stated V30 has trained V29 licensed pending LPN. V30 stated V29 did pass pills with V3 supervising V29. V29 administered the medications to the residents. V30 stated V29 gave by mouth medications, a couple of subcutaneous medications, eye drops, and breathing treatments. V30 stated V29 administered the medications for the whole west hallway. V30 stated V29 passed medications on that hallway twice and administered the medications at the 4:00 PM and 8:00 PM medication pass. The facility's west hallway resident listing sheet provided by V1 Administrator documents R2, R9, R10 through R18, R20, R21, R23 through R34 receive medications on the 4:00 PM medication pass. This sheet documents R12, R14, R2, R16, R18, R19, R22, R24, R28, R29, R30, R33, R34, and R35 receive medications on the 8:00 PM medication pass. On 8/26/20 at 12:43 PM, V1 Administrator stated the facility follows the Illinois Nurse Practice Act for licensed pending nurses. V1 stated an employee has to be a nurse to pass medications. V29 should not have been passing medications to the residents under V30's supervision. V1 stated V29 has not passed V29's nursing license exam. V1 stated V30 and V29 worked on the west hallway on 8/13/20 and 8/14/20. The Illinois PROFESSIONS, OCCUPATIONS, AND BUSINESS OPERATIONS (225 ILCS 65/) Nurse Practice Act. states under Sec. 55-10. LPN licensure by examination that (d) A licensed practical nurse applicant who passes the Department-approved licensure examination and has applied to the Department for licensure may obtain employment as a license-pending practical nurse and practice as delegated by a registered professional nurse or an advanced practice registered nurse or physician. An individual may be employed as a license-pending practical nurse if all of the following criteria are met: (1) He or she has completed and passed the Department-approved licensure exam and presents to the employer the official written notification indicating successful passage of the licensure examination. (2) He or she has completed and submitted to the Department an application for licensure under this Section as a practical nurse. (3) He or she has submitted the required licensure fee. (4) He or she has met all other requirements established by rule, including having submitted to a criminal history records check. The facility's Medication Administration policy dated 11/18/17 documents, Drugs and biologicals are administered only by physicians and licensed nursing personnel.