PRINTED: 10/09/2014 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	145584	B. WING _	B. WING		C 0/03/2014	
	N		STREET ADDRESS, CITY, STATE, ZIP CO 1000 PALM MATTOON, IL 61938		0/00/2014	
(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETION DATE	
INITIAL COMMENT	rs	F 00	00			
Complaint # 14639	017 / IL71838-No deficiency					
Complaint # 146394	41 / IL71863-No deficiency					
Complaint # 146410 F225, F226, F241	05 / IL72043-F155, F221,					
Complaint # 146416 F226, F279	67 / IL72110-F223, F225,					
Complaint # 146423	30 / IL 72193-F159					
483.10(b)(4) RIGH	T TO REFUSE; FORMULATE	F 15	55			
refuse to participate and to formulate an	e in experimental research, a advance directive as					
specified in subpart related to maintaining procedures regarding requirements include provide written inforconcerning the right or surgical treatmer option, formulate ar includes a written depolicies to impleme	It I of part 489 of this chaptering written policies and ing advance directives. These de provisions to inform and imation to all adult residents it to accept or refuse medical int and, at the individual's in advance directive. This escription of the facility's int advance directives and					
	PROVIDER OR SUPPLIER ERRACE OF MATTOO SUMMARY STA (EACH DEFICIENCY REGULATORY OR L INITIAL COMMENT Complaint # 14639 Complaint # 14641 F225, F226, F241 Complaint # 14641 F226, F279 Complaint # 14642 A partial extended s 483.10(b)(4) RIGHT ADVANCE DIRECT The resident has the refuse to participate and to formulate an specified in paragra The facility must co specified in paragra	IDENTIFICATION NUMBER: 145584 PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS Complaint # 1463917 / IL71838-No deficiency Complaint # 1464105 / IL72043-F155, F221, F225, F226, F241 Complaint # 1464167 / IL72110-F223, F225,	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS Complaint # 1463941 / IL71838-No deficiency Complaint # 1464105 / IL72043-F155, F221, F225, F226, F241 Complaint # 1464230 / IL 72110-F223, F225, F226, F279 Complaint # 1464230 / IL 72193-F159 A partial extended survey was conducted. 483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and	THE CORRECTION IDENTIFICATION NUMBER: 145584 145584 B. WING STREET ADDRESS, CITY, STATE, ZIP CO 1000 PALM MATTOON, IL 61938 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS Complaint # 1463917 / IL71838-No deficiency Complaint # 1463941 / IL71863-No deficiency Complaint # 1464105 / IL72043-F155, F221, F225, F226, F241 Complaint # 1464167 / IL72110-F223, F225, F226, F279 Complaint # 1464230 / IL 72193-F159 A partial extended survey was conducted. 483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in subpart 1 of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and	THE CORRECTION DENTIFICATION NUMBER: 145584 B. WING	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

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.

TITLE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (V41) PROVIDED (SUBDILITATION AND HUMAN SERVICES

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		145584	B. WING _		10	C 0/ 03/2014
	PROVIDER OR SUPPLIER	DN .		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 PALM MATTOON, IL 61938		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 155	Continued From pa	age 1	F 15	5		
	by: Based on record refailed to permit one refuse the use of a three residents revisample of eighty ni Findings include: R7's Physician Ord 9/30/14 documents Chorea with associbehaviors, Anxiety, and Disuse Atrophy R7's Minimum Data documents Brief In (BIMS) as 10/15 (m 9/25/14 at 9:22 am (R7's) cognition is i	ler Sheet (POS) dated 9/1/14 - s diagnoses of Huntington's iated Dementia without Depression, Muscle Wasting				
	I believe that is ned	cessary for (R7) to speak more ton's affecting her speech				
	Assistant (CNA) sta), (R7) was gotten in nurses station so s stated that "the nur stooped down besi was trying to stand behave. " E19 state sheet tied tight eno her wheelchair so s irritated and kept ti	am E19, Certified Nursing ated that "(E18, CNA) told (E19 up out of bed and taken to the he wouldn't fall." E19 then se (E17, Registered Nurse) de the wheelchair while (R7) up and heard (E17) tell (R7) to ed "I saw that (R7) had a bed ough around her, to keep her in she wouldn't fall. (R7) was very rying to tell (E17) that she d.(R7) was louder than she				

-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145584	B. WING				C 03/2014
	PROVIDER OR SUPPLIER	DN .		STREET ADDRE 1000 PALM MATTOON, IL	SS, CITY, STATE, ZIP CODE	10/	03/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECTION I CORRECTIVE ACTION SHOULI REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 155	usually was when I On 9/23/14 at 4:38 to bed and got on have a (disposal she could go (uring to(R7) continue of bed and on the case wheel chair, she (Fasher when we brought honcoming nurse is the arms of the who bucking and the wanted her (R7) colling for any colling her she would take her to the needed to go and proceeded to go and proce	worked." pm, E17 stated " (R7) was put her call light constantly. (R7) ble incontinence brief) on so ate) in her bed if she wanted hed restless, trying to climb out call light. We got her up in the light was a hospital gown on her to the nurses station. The male so I tied the bed sheet to held the light her pelvis forwardI be report. I told (E18) to come with the sheet I'm talking to be needed to calm down. We he bathroom anytime she but her in bed, once she was nort and did some paper work, (R7) was still in the chair and	F 1	55			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG	` '	(X3) DATE SURVEY COMPLETED	
		145584	B. WING	B. WING		C (03/2014	
	PROVIDER OR SUPPLIER	N		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 PALM MATTOON, IL 61938			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPROPRIES OF THE	JLD BE	(X5) COMPLETION DATE	
F 155	wanted to go to bee She (R7) is a fall risher (R7) up and brobecause she kept the was yelling she war and E18) told her (I we'd put her in bed on one side of the vitied the other to the arm." On 9/23/14 at 4:10 Nurse stated that of Certified Nursing At E17 had tied R7 in 9/5/14. The Facility Admission documents that a Vice Residents Rights with treatment is signed admission. 483.10(c)(2)-(5) FAPERSONAL FUND Upon written author facility must hold, so account for the periodeposited with the facility must defunds in excess of standard residence.	In hollering and yelling that she is but she wouldn't stay in bed. It she wouldn't stay in bed. It she wouldn't stay in bed. It she wouldn't stay in get out of bed. It she would to go to bed. It she would to go to bed. It she would the she would the she wheel chair arm and I (E18) is bar in front of the wheel chair in front of the wheel chair wheel chair with a sheet on the wheelchair with a sheet on wheelchair with a sheet on which include a right to refuse as part of the contract on It is contract on	F 1	55			
	all interest earned	ng accounts, and that credits on resident's funds to that d accounts, there must be a					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (V41) PROVIDED (SUBDILITATION AND HUMAN SERVICES

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		145584	B. WING			C 03/2014
	PROVIDER OR SUPPLIER	ON .		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 PALM MATTOON, IL 61938	1 10	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
F 159	The facility must m funds that do not expearing account, in petty cash fund. The facility must expected that assures a full accounting, accord accounting principle funds entrusted to behalf. The system must president funds with of any person other. The individual finanthrough quarterly sthe resident or his of the resident or his of the resident's account SSI resource limit from the facility must not make the section 1611(a)(3)(amount in the account resident's other reaches the SSI resource the resident may lose of the resident may lose of the facility must not make the section 1611(a)(3)(amount in the account resident may lose of the resident may lose of the facility must not make the section 1611(a)(3)(amount in the account resident may lose of the facility must not make the section 1611(a)(3)(amount in the account resident may lose of the facility must not make the section 1611(a)(3)(amount in the account resident may lose of the facility must not make the section 1611(a)(3)(amount in the account resident may lose of the facility must not make the section 1611(a)(3)(amount in the account resident may lose of the facility must not make the section 1611(a)(3)(amount in the account resident may lose of the facility must not make the section 1611(a)(3)(amount in the account resident may lose of the facility must not make the section 1611(a)(3)(amount in the account resident may lose of the facility must not make the section 1611(a)(3)(amount in the account resident may lose of the facility must not make the section 1611(a)(3)(amount in the account resident may lose of the facility must not make the section 1611(a)(a)(a)(a)(a)(a)(a)(a)(a)(a)(a)(a)(a)(age 4 ag for each resident's share.) aintain a resident's personal acceed \$50 in a non-interest atterest-bearing account, or stablish and maintain a system and complete and separate ing to generally accepted es, of each resident's personal the facility on the resident's preclude any commingling of facility funds or with the funds or than another resident. Incial record must be available tatements and on request to por her legal representative. Intity each resident that receives when the amount in the reaches \$200 less than the for one person, specified in B) of the Act; and that, if the aunt, in addition to the value of or nonexempt resources, source limit for one person, the deligibility for Medicaid or SSI. NT is not met as evidenced eview and interview, the facility at 89 of 133 residents (R1, R3 R14, and R17 through 94) and deposited in the pooled		9		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI IER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		145584	B. WING _			C 03/2014
	PROVIDER OR SUPPLIER	DN .		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 PALM MATTOON, IL 61938	1 10/	00/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 159	for resident use im deposits. The finding include E22, Business Office Ma 10-1-14 at 10:00 A procedure for man Resident Trust Fur held in an interest laccount in a local broad and checks remajority of the deposits Social Security check the individual resident Corporate Office. It transmits the list an individual resident's Fund Account. This transmitted to the deposit was maded deposit information E23 creates a spread the Social Security individual resident posted to the resident resident Trust Fund does not give fundative resident Trust Fund does not give fundative resident. E22 at a fundation.	ecking account are available mediately following the second and E23, anager were interviewed on .M. regarding the facility's agement and handling ads. Resident Trust Funds are bearing pooled checking bank. E23 makes deposits of eceived at the facility. The osits at made as direct of the resident's monthly ecks. E23 and E22 stated that ent deposits are posted by the E23 stated that the local bank and the amounts of the second to the amounts of the example as a stated that once the awas transmitted to facility, eadsheet of the amounts from checks to be posted in the account and the amount to ent liability. E23 stated that the asmitted to the Corporate office	F 15	9		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
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	NAME OF PROVIDER OR SUPPLIER PALM TERRACE OF MATTOON			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 PALM MATTOON, IL 61938		
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F 159	by Corporate office facility's "Resident the following: Residents, Date of Corporate R17, R18, R19, 9- ", 8- ", 7-3-14 ", 6-3-14 ", 5-2-14 According to the "S	aples of the delays in posting for R17, R18, and R19. The Trust Fund Inquiry" showed deposit, Date posted by 3-14, 9-10-14 1-14, 8-6-14 , 7-8-14 , 6-4-14	F 15	59		
F 221 SS=G	Fund Balance Reporesidents (R1, R3 t R17 through 94) had in the pooled intered. The 89 residents the checks deposited, monies until the detheir account. The facility's "Resident Procedure" states a paragraph, "In this access to his/her managraph refered facility. 483.13(a) RIGHT THYSICAL RESTRE	ort as of 9-30-14", 89 of 133 hrough R10, R13, R14, and ave resident funds deposited st being checking account. Nat have their Social Security have to wait to have their posit is credited (posted) to dent Funds Policy and at the end of the first manner the resident will have nonies within the same day." Pers to funds deposited with the TO BE FREE FROM	F 22	21		
	physical restraints i	mposed for purposes of nience, and not required to				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	N		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 PALM MATTOON, IL 61938		70072011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 221		ge 7 medical symptoms. NT is not met as evidenced	F 22	.1		
	by: Based on observatinterview, the facilit restraint assessme and physician's ord Nursing staff applie that was not necessymptom, but rathe failure resulted in F	tion, record review and y failed to complete a physical nt, obtain informed consent er for the use of a restraint. It a physical restraint to R7 sary to treat a medical er for staff convenience. This R7 being distraught and fearful. The residents reviewed for physical				
	9/30/14 documents Chorea with associ	er Sheet (POS) dated 9/1/14 - diagnoses of Huntington's ated Dementia without Depression, Muscle Wasting //				
	documents a Brief (BIMS) as 10/15 (m 9/25/14 at 9:22 am (R7)'s cognition is i reliable. Staff have I believe that is neo	a Set (MDS) dated 8/15/14 Interview for Mental Status hild cognitive impairment). On , Z2, Psychiatrist stated that " ndeed intact, she is very told me that (R7) can get loud, ressary for (R7) to speak more on's affecting her speech				
	Assistant (CNA) sta	O am E13, Certified Nursing ated " (R7) does get up by rom her wheelchair when she				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		145584	B. WING		1	C 0/03/2014
	PROVIDER OR SUPPLIER)N		STREET ADDRESS, CITY, STATE, ZIP (1000 PALM MATTOON, IL 61938		0/00/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE
F 221	you how I can get to wheelchair." R7 sor recliner chair, checked on her assistance facing the sat down. On 9/25/14 at 10:3: little but need help my room and use the falling." On 9/24/14 at 1:00 was up at the nurse that she wanted to stay in bed. She (R second shift got he the nurses station to out of bed. (R7) was bed. We (E17, Regher (R7)when she bed Then (E17) the wheel chair arm the bar in front of the On 9/23/14 at 4:38 to bed and got on hwanted a (disposal she could go (urina to (R7) continue of bed and on the cowheel chair, she (F when we brought honcoming nurse is the arms of the who was bucking a forward I wanted	age 8 5 am R7 stated "I will show up and transfer to my coted to the front of her ked to make sure the brakes wheel chair, stood without he chair, turned around and 5 am R7 stated "I can walk a with long distances. I get up in he furniture to keep me from pm E18, CNA stated "(R7) es station hollering and yelling go to bed but she wouldn't (R7) is a fall risk that's why r (R7) up and brought her to because she kept trying to get is yelling she wanted to go to jistered Nurse and E18) told calmed down we'd put her in tied the sheet on one side of and I (E18) tied the other to be wheel chair arm." pm, E17 stated "(R7) was put her call light constantly. (R7) ble incontinence brief) on so the incontinence brief on an		221		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145584	B. WING	B. WING		C 0/ 03/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1000 PALM MATTOON, IL 61938	•	
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F 221	help me with the sitelling her she nee take her to the bat go and put her in be finished report and little late and (R7) not calmed down." On 9/25/14 at 5:30 Assistant (CNA) st (E19,CNA), (R7) we taken to the nurses E19 then stated th Nurse, RN) stoope while (R7) was tryitell (R7) to behave had a bed sheet tikkeep her in her wh (R7) was very irrita (E17) that she war louder that she use heard (E17) tell (R and wouldn't in state on 9/25/14 at 8:05 he received in report and put R7 at the rishe doesn't fall. On 9/24/14 at 8:25 scared then (9/5/14 the same nurse (Enight. (E17) kept to wanted to go to the underpants and hawhen the nurse (Enot wear that diaped	t. I told (E18) to come over and heet I'm talking to (R7) ded to calm down. We would hroom anytime she needed to bed, once she was calm. I did some paper work, left a was still in the chair and had a man E19, Certified Nursing ated that "(E18, CNA) told was gotten up out of bed and as station so she wouldn't fall." at "the nurse (E17, Registered and down beside the wheelchairing to stand up and heard (E17). "E19 stated "I saw that (R7) are tight enough around her, to eelchair so she wouldn't fall. Ited and kept trying to tell ated to go to bed." "(R7) was ually was when I worked." "I 7) that (R7) was already in bed	F 2	21		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		145584	B. WING		10/	03/2014	
	PROVIDER OR SUPPLIER RRACE OF MATTOO	N .		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 PALM MATTOON, IL 61938			
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F 221	did it." " (E17) would wheel chair so I find	age 10 B) don't like me that's why they dn't take it (bed sheet) off my ally got the sheet untied took me to the bathroom and	F 2	21			
	restraint assessme consent, a physicia physical restraint a symptom being trea On 9/25/14 at 9:55 stated "I looked in h restraint assessme	vas devoid of a physical nt, documentation of informed ns order for application of a nd identification of a medical ated by the physical restraint. am, E2, Director of Nursing ner (R7) chart too, there is no nt, consent or order from her raint we viewed this as a					
	documents that "a pused for the purpos and must treat a phinclude: "A complete restrainal physicians order."	c)(1)(i) FREE FROM	F 2	23			
	sexual, physical, ar	ne right to be free from verbal, nd mental abuse, corporal voluntary seclusion.					
		ot use verbal, mental, sexual, corporal punishment, or on.					
	This REQUIREMEN	NT is not met as evidenced					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER PALM TERRACE OF MATTOON				DE		
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORF X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
failed to prevent a wit R8 by R9 which result right femoral neck frateight residents review of eighty nine. Findings include: R9's Admission Face R8's Admission Face R9's Physician Order 9/30/14 documents of Depression and Blind diagnoses of Schizop R9's admission asset 11/6/13 documents the physical violence and harm. There was not R9's physical aggress R9's Minimum Data Stocuments a Brief Interval (BIMS) of 11/15 (mile R8's MDS dated 7/17 score of 14/15 (no consideration	and record review, the facility tnessed physical assault on lted in a right humerus and acture. R8 and R9 are two of wed for abuse in the sample. Sheet is dated 11/06/13. Sheet is dated 11/07/13. Sheet (POS) dated 9/1/14 - diagnoses of Schizophrenia, dness. R8's POS documents ohrenia and Epilepsy. Ssment for violence dated that R9 has had a history of did the physical ability to cause of documented evidence of sion toward others on file. Set (MDS) dated 7/21/14 terview for Mental Status did cognitive impairment). T/14 documents a BIMS ognitive impairment). On Z2, Psychiatrist stated " (R9) the (R9) is very aware of what ognitively intact and I am not on of aggression towards signed by E12, Registered and 9/19/14 at 5:00 pm was in the dining room and	F 2	223			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (V41) PROVIDED (SUBDILITATION AND HUMAN SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	COM	E SURVEY IPLETED
		145584	B. WING _			C 03/2014
	TO PLAN OF CORRECTION IDENTIFICATION NUMBER: 145584 ALM TERRACE OF MATTOON (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 PALM MATTOON, IL 61938	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 223	the roomResider room after this incide room after this incide complaining about On 9/25/14 at 9:05 the dining room who cup hit me and the and R15). Then (Risue me." On 9/25/14 at 9:40 my table when (R9) hit (R10 and R14). I hadn't been leaving the leaving of coffed directly at me. Hot arm. Three CNA Strunning. Then anot room." On 9/24/14 at 2:10 Assistant (CNA) statook him to his room hands. He (R9) sain R9 remained in his in the dining room. R9's Facility Nursin Registered Nurse (6:00 pm documents CNA) to push another contacts. The contacts are contacts and contacts are contacts. The contacts are contacts are contacts and contacts are contacts and contacts are contacts. The contacts are contacts are contacts are contacts are contacts. The contacts are contacts are contacts are contacts are contacts. The contacts are contacts are contacts are contacts are contacts are contacts are contacts. The contacts are contacts are contacts are contacts are contacts are contacts. The contacts are contacts are contacts are contacts are contacts are contacts. The contacts are contacts are contacts are contacts are contacts are contacts. The contacts are contacts are contacts are contacts are contacts are contacts. The contacts are contacts are contacts are contacts are contacts are contacts are contacts. The contacts are contacts are contacts are contacts are contacts are contacts are contacts. The contacts are contacts. The contacts are contacts. The contacts are contacts are contacts are contacts are contacts are contacts are contacts. The contacts are contacts are contacts are contacts are contacts are contacts are contacts. The contacts are contacts are contacts are contacts are contacts are contacts are contacts. The contacts are contacts. The	ent was helped back to his dent as other residents were being made wet." am, R10 stated "I was out in en (R9) threw his coffee. The coffee landed on them (R149) said 'I threw the coffee, so am, R15 stated "I was leaving) threw the cup of coffee and I was in a direct line to be hit if not the staff as (R9) raised e, aimed at me and threw it coffee got all down my left aff (unknown names) came her CNA (E15) took (R9) to his pm, E15 Certified Nursing ated "(R9) spilt his coffee and I m to helped him wash his d he was going to take a nap." room while others continued g Notes, signed by E12, RN) and dated 9/19/14 at s " (R9) was seen by (E10,	F 22			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		COMPLETED					
		145584	B. WING				C (03 / 2014
	PROVIDER OR SUPPLIER	I		100	REET ADDRESS, CITY, STATE, ZIP CODE O PALM TTOON, IL 61938	1 10/	03/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)) BE	(X5) COMPLETION DATE
F 223	On 9/24/14 at 2:30 to the floor Stat (im floor. I knew right a broken, it was rotat complained of pain told me that (R8) no (which is connected yelling about it whe (E10) told me (R8) on his right side."	pm, E12 stated "I was called mediately), (R8) was on the way that his (R8) leg was red outward and he in his leg and shoulder. (E10) eeded to use the bathroom d to R9's room) they were in (E10) saw (R9) push (R8). flew across the room landing		223			
	worked the night (F usually calm (R9) o (R9) kept saying I was on the floor in	pm, E25 CNA stated " I R9) pushed (R8) down. I can lown but not that night. He want to fight him (R8)R8 his (R8) room and (R9) just In't calm him (R9) down so came to help me."					
	night since I've bee the bathroom to RS nights (R9) wakes yellingNow I kno of, it's not just (R9)	pm, R8 stated " about every en in this room (connected by 9's room) every couple of me up slamming doors and by what he's (R9) is capable threatening me now he hurt me again. I can't continue e of this assault."					
	8:17 pm document fracture and a right	oom Note dated 9/19/14 at s R8 suffered a right femur humerus fracture and was al for surgical repair.					
	7:33 pm document right posterior trape another resident (F on 9-24-14 at 2:30	oom Note dated 9/19/14 at s that R9 was treated for a ezius strain after he punched R8) at the facility. E12 stated p.m. that R9 was returned to sed on a behavioral care unit					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			COMPLETED			
		145584	B. WING _		10	C)/03/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 PALM MATTOON, IL 61938		703/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 223 F 225 SS=F	Program" dated 11/Residents who resident will be rem residents during the The accused reside immediately evalua suitable therapy, ca placement, conside as the safety of other facility" 483.13(c)(1)(ii)-(iii), INVESTIGATE/REF ALLEGATIONS/INDESTIGATE/REF ALLEGATIONS/INDEST	itled "Abuse Prevention 11/11, documents allegedly mistreat another oved from contact with other ecourse of the investigation. In the ted to determine the most are approaches and uring his or her safety, as well er residents and employees of (c)(2) - (4) PORT DIVIDUALS It employ individuals who have f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a can employee, which would or service as a nurse aide or the State nurse aide registry ties. Issure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law if procedures (including to the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145584	B. WING _		10	C / 03/2014	
	PROVIDER OR SUPPLIER	DN .		STREET ADDRESS, CITY, STATE, ZIP COD 1000 PALM MATTOON, IL 61938		, ••, ••	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 225	violations are thorous prevent further pot investigation is in positive and into the administrator epresentative and with State law (inclicertification agency incident, and if the	ave evidence that all alleged bughly investigated, and must ential abuse while the progress.	F 22	25			
	by: A. Based on recordacility staff failed to abuse of R7 when applied against helprotect R7 and oth perpetrators to have access to all reside identify this as alled delay in the abuse allegation to the St of eight residents reample of eighty ni	rd review and interview, the oridentify and report possible a physical restraint was rewishes. The facility failed to ers by permitting the alleged recontinued unrestricted ents. The facility also failed to ged abuse which caused a investigation and report of the ate Survey Agency. R7 is one eviewed for abuse in the ne. These failures have the all 145 residents residing in the					
	9/30/14 documents Chorea with assoc	ler Sheet (POS) dated 9/1/14 - s diagnoses of Huntington's iated Dementia without Depression, Muscle Wasting					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145584	B. WING _			C / 03/2014	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 PALM MATTOON, IL 61938			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 225	documents a Brief (BIMS) as 10/15. OPsychiatrist stated intact, she is very r (R7) can get loud, R7 to speak more affecting her speed On 9/25/14 at 5:30 Assistant (CNA) st CNA), (R7) was gothe nurses station stated that "the nurses oped down besi was trying to stand behave. " E19 states sheet tied tight end her wheelchair so sirritated and kept twanted to go to be usually was when that (R7) was alreathere." On 9/23/14 at 4:38 to bed and got on I wanted a (disposal she could go (urin to(R7) continue of bed and on the collection of the coll	a Set (MDS) dated 8/15/14 Interview for Mental Status on 9/25/14 at 9:22 am, Z2, that " (R7) cognition is indeed eliable. Staff have told me that I believe that is necessary for clear with Huntington's ch delivery." am E19,Certified Nursing ated that "(E18, CNA) told (E19 of the up out of bed and taken to so she wouldn't fall." E19 then rese (E17, Registered Nurse) de the wheelchair while (R7) up and heard (E17) tell (R7) to ed " I saw that (R7) had a bed ough around her, to keep her in she wouldn't fall. (R7) was very rying to tell (E17) that she d." "(R7) was louder than she worked. I heard (E17) tell (R7) ody in bed and wouldn't in stay pm, E17 stated " (R7) was put her call light constantly. (R7) ole incontinence brief) on so ate) in her bed if she wanted ed restless, trying to climb out call light. We got her up in the	F 22	5			
	when we brought honcoming nurse is the arms of the who was bucking a forwardI wante	R7) had on a hospital gown on her to the nurses station. The male so I tied the bed sheet to eel chair to cover the resident and thrusting her pelvis d her (R7) covered for her own to (E14, LPN) report. I told (E18)					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145584	B. WING _			C / 03/2014	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 PALM MATTOON, IL 61938			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 225	talking to (R7) tellir down. We would to anytime she needed once she was calm some paper work, still in the chair and On 9/25/14 at 8:05 he received in report and put R7 at the reshe doesn't fall. On 9/24/14 at 8:25 scared then (9/5/14 the same nurse (Enight. (E17) kept to wanted to go to the underpants and hawhen the nurse (Enot wear that diaped bed sheet behind to They (E17 and E18 did it." " (E17) would wheel chair so I fin myself, then (E18) let me go to bed." On 9/24/14 at 1:00 at the nurses static wanted to go to be She (R7) is a fall rither (R7) up and brobecause she kept was yelling she way and E18) told her (we'd put her in becon one side of the some static of the some side of the some she was gothern than the some side of the some side side side side side side side sid	age 17 nelp me with the sheet I'm ng her she needed to calm like her to the bathroom ed to go and put her in bed, n. I finished report and did left a little late and (R7) was d had not calmed down." am E14 stated that on 9/5/14 out from E17 that E17 got R7 up nurses station to watch her so am, R7 stated " I was really 4) and again last night, that's 17) who was working that elling me I was bad because I e bathroom I wear d those and a nightgown on 17)got mad because I would er (E17) and (E18) tied the he back of my wheelchair. B) don't like me that's why they dn't take it (bed sheet) off my ally got the sheet untied took me to the bathroom and pm E18 stated " (R7) was up on hollering and yelling that she d but she wouldn't stay in bed. sk that's why second shift got ought her to the nurses station trying to get out of bed. (R7) nted to go to bed. We (E17 R7)when she calmed down I Then (E17) tied the sheet wheel chair arm and I (E18) e bar in front of the wheel chair	F 22				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145584	B. WING		10	C / 03/2014	
	PROVIDER OR SUPPLIER	DN .		STREET ADDRESS, CITY, STATE, ZIP COL 1000 PALM MATTOON, IL 61938	•	, 00, 20 1 1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 225	Nurse (LPN) stated Certified Nursing A E17 had tied R7 in 9/5/14. E21 reported Director of Nursing On 9/24/14 at 10:2 reported the allegate when she came in On 9/24/14 at 10:3 thought it (tying the was for R7's digniting the evening of 9/8/abuse." On 9/24/14 at 9:50 The (E2) Director of (9/5/14, R7 being rabuse. I was informinvestigated it as a been interpreted at Nurse/Certified Nudocuments that on before an investigate continued to work	pm, E21, Licensed Practical In that on 9/7/14 night shift E19, ssistant (CNA) told E21 that the wheelchair with a sheet on ed this to E20, Assistant (ADON) 9/8/14 at 6:00 am. 5 am, E20 stated that she tion to E2, Director of Nursing the morning of 9/8/14. 0 am, E2 stated that she bed sheet to the wheel chair) and confirmed this with E17 14. "I did not view this as am, E1, Administrator stated of Nursing did not view this estrained with a bed sheet) as ned on 9/9/14, reported and buse because it could have a abuse." The facility rsing Assistant (CNA) schedule 9/8/14, E17 continued to work attion was initiated. E18 9/8/14, 9/9/14 and 9/10/14	F2	25			
	restrained with a b perpetrators, E17a access to all reside initiated 9/9/14. The Investigation F State Survey Agen	the investigation into R7 being ed sheet. The alleged and E18 had unrestricted ents until the investigation was report documents that the cy was not notified until an of the incident that occurred					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145584	B. WING				0
NAME OF F		145564	D. WING		TREET ADDRESS SITY STATE 71D SODE	10/0	03/2014
	PROVIDER OR SUPPLIER	N		1	TREET ADDRESS, CITY, STATE, ZIP CODE 000 PALM MATTOON, IL 61938		
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F 225	Continued From pa	ge 19	F 2	25			
	Facility Data Sheet census of 145.	dated 9/11/14 documents a					
	facility failed to protincident when R9 h residents (R10, R14 R9 then assaulted I and femur fracture. alleged physical abreport it, investigate prevent the physica R14 and R15 are fifor abuse in the sar failures have the poresidents residing in	I review and interview the lect R8 from R9 after an ad thrown coffee at other 4 and R15) in the dining room. R8 who suffered a humerus Staff had knowledge of this use and failed to identify it, e it and provide protection to all abuse on R8. R8, R9, R10, we of eight residents reviewed imple of eighty nine. These otential to affect all 145 in the facility.					
	Findings include:	ce Sheet is dated 11/06/14.					
	R9's Admission Ass 11/6/13 documents	sessment for Violence dated that R9 has had a history of high the physical ability to cause					
		er Sheet dated 9/1/14 - diagnoses of Schizophrenia, ndness.					
	documents a Brief (BIMS) of 11/15 (mi 9/25/14 at 9:22 am,	a Set (MDS) dated 7/21/14 Interview for Mental Status ild cognitive impairment). On , Z2, Psychiatrist stated " (R9) . He (R9) is very aware of what					
	R9's Nurse Notes s	signed by E12, Registered					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		145584	B. WING _		10	C / 03/2014	
	PROVIDER OR SUPPLIER	N		STREET ADDRESS, CITY, STATE, ZIP CO 1000 PALM MATTOON, IL 61938	•	70072011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 225	Nurse and dated 9/ "resident was in the coffee. He (R9) flur roomResident wa after this incident at complaining about Nurses Note is dev to prevent R9 from others. R9's Nursing Notes Nurse and dated 9 (R9) was seen by s (R8) from the next by staff initiated." R9's Nursing Notes Nurse (RN) and dadocument (R9) ask wanted to fight (R8) On 9/24/14 at 2:10 Assistant (CNA) statook him to his roor He (R9) said he wall headed back downroom." On 9/25/14 at 9:05 the dining room who cup hit me and the and R15). Then (R9) sue me'." On 9/25/14 at 9:40 my table when (R9)	19/14 at 5:00 pm document edining room and drinking ing his coffee across the was helped back to his room is other residents were being made wet." This same oid of any intervention initiated further aggression towards 15, signed by E12, Registered in it is in in it is in it in it is in it in it is in it in it in it is in it in	F 22	25			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145584	B. WING			C 10/03/2014	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 1000 PALM MATTOON, IL 61938		10/03/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 225	On 9/25/14 at 4:15 yelling help, help, hhis hot cup of coffe directly at me. Hot carm. Three CNA Strunning. Then anot room." R9 remaineresidents continued. The Investigation From the alleged abust reported to the E1, Agency or investigating allegation to the at 10:00 am. Facility Data Sheet census of 145. C. Based on record facility failed to ider provide protection as exual abuse by an facility subsequently to the State Survey residents reviewed eighty nine. These affect all 145 reside. Findings include: R9's Physician Ord 9/30/14 documents Depression and Blisteria are survey and survey residents reviewed eighty nine. These affect all 145 reside.	pm, R14 stated "I started elp to the staff as (R9) raised e, aimed at me and threw it coffee got all down my left aff (unknown names) came her CNA (E15) took (R9) to his ed in his room while other in the dining room. Report documents R9 threw to 5:00 pm. (E12 documented 19/14 that he had knowledge se). This allegation was not Administrator, State Survey ated until the surveyor reported e E1, Administrator on 9/25/14 dated 9/11/14 documents a life review and interview the ntify, report, investigate and after R9 disclosed alleged unknown perpetrator. The y failed to report the allegation Agency. R9 is one of eight for abuse in the sample of failures have the potential to ents residing in the facility.		225			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (V1) PROVIDED (SUBBLIFB) OF THE SERVICES

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			COMPLETED			
		145584	B. WING _		10	C / 03/2014
	TO PLAN OF CORRECTION IDENTIFICATION NUMBER: 145584 AME OF PROVIDER OR SUPPLIER ALM TERRACE OF MATTOON (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 PALM MATTOON, IL 61938		700/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 225	documents a Brief (BIMS) of 11/15 (M 9/25/14 at 9:22 am is cognitively intact he is doing." R9's Nursing Note: Practical Nurse (Lf am, documents the slamming doors at man touched my p that man told me my penis, but I am On 9/24/14 at 11:5 man in the mirror to the saw it in the nuture (surveyor) regarding (allegation) on (R8) The Investigation of State Survey Agen 9/23/14 at 18:56 proposed and investigation of same report documents.	Interview for Mental Status lild cognitive impairment). On , Z2, Psychiatrist stated " (R9) . He (R9) is very aware of what es, signed by E11, Licensed PN) and dated 8/22/14 at 5:45 at " resident began yelling and 5:15 am (R9) complained that enis, the yelling started when ot to tell anyone he touched going to tell." 7 am E11 stated "(R9) said the old him not to tell anyone that a enis I did not report what he g his penis because he referred nirror." pm R9 stated " I can't y trying to touch my penis nappened in the past. That's all that." ector of Nursing stated " we se sexual abuse allegation until rses notes we copied for young (R9) physical assault	F 22	5		

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		CON	(X3) DATE SURVEY COMPLETED		
		145584	B. WING _			C / 03/2014
	PROVIDER OR SUPPLIER	N		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 PALM MATTOON, IL 61938	1 10	(00/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 225	Continued From pa Facility Data Sheet census of 145.	ge 23 dated 9/11/14 documents a	F 22	25		
F 226 SS=F	The Facility Policy to Program" dated 11/employees "report a suspicion of potenti misappropriation of about, or suspect to immediate supervise the administrator inform the administrator, the pof all reports, incided potential abuse, need property. Upon lear administrator, or in administrator the poshall initiate an incide investigationRe another resident will with other resident will with other residents investigation. The ashall be immediated most suitable thera placement, consider as the safety of other the facilityEmploy been accused of misappropriation of immediately remove the results of the investigation. The additional suitable thera placement, consider as the safety of other facilityEmploy been accused of misappropriation of immediately remove the results of the investigation.	erson in charge of the facility, dent sidents who allegedly mistreat II be removed from contact a during the course of the accused resident's condition y evaluated to determine the py, care approaches and ring his or her safety, as well er residents and employees of yees of the facility who have istreatment, neglect, abuse or residents property will be ed from resident contact until vestigation have been ministrator or designee." P/IMPLMENT	F 23	26		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
	145584	B. WING		1	C 0/03/2014	
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(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI TAG	X (EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETION DATE	
policies and proced mistreatment, negle and misappropriation This REQUIREMEN by:	lures that prohibit ect, and abuse of residents on of resident property.	F 2	226			
A. Based on interver facility failed to ope effectively identify pand staff, report alled perpetrators, invest report to the State Stailed to identify, repossible abuse who applied against her perpetrators had corresidents. The facility after an incident who three other resident dining room. R9 the a humerus and fem knowledge of and far a possible allegation investigate. The facility stoperstate and prodisclosed alleged superpetrator to E11 Let (LPN). The facility stoperstate in the sar failures have the porresidents residing in the sar failures have the porres	rationalize their policy to potential abuse by residents aged abuse, remove alleged igate allegations of abuse and Survey Agency. The facility port and protect R7 from an physical restraint was (R7) wishes. The alleged antinued access to all ity failed to protect R8 from R9 pere R9 had thrown coffee at its (R10, R14 and R15) in the an assaulted R8 who suffered alled to identify this incident as n of abuse, failed to report and alled to identify this incident as n of abuse, failed to report and illity failed to identify, report, wide protection after R9 exual abuse by an unknown cicensed Practical Nurse subsequently failed to report Agency. R7, R8, R9, R10, ix of eight residents reviewed imple of eighty nine. These prential to affect all 145					
Findings include :						
	Continued From particles and proceded mistreatment, negler and misappropriation. This REQUIREMENT by: A. Based on interviacility failed to operfectively identify pand staff, report aller perpetrators, investing report to the State of failed to identify, repossible abuse who applied against her perpetrators had corresidents. The facility after an incident who three other resident dining room. R9 the a humerus and ferm knowledge of and far a possible allegation investigate and prodisclosed alleged significant perpetrator to E11 L (LPN). The facility sto the State Survey R14 and R15 are significant produced in the sar failures have the possible have the possible in the sar failures have the possible have the possible in the sar failures have the possible have	This REQUIREMENT is not met as evidenced by: A. Based on interview and record review, the facility failed to operational jze their policy to the State Survey Agency. The facility failed to protect R8 from Possible adjusts when physical restraint was applied against her (R1) wishes. The alleged perpetrators had continued a humerus and femur fracture. Staff had knowledge of and failed to identify, report, investigate allegation of resident as a possible allegation of abuse, failed to report and investigate. The facility failed to report and protect R8 from R9 after an incident where R9 had thrown coffee at three other residents (R10, R14 and R15) in the dining room. R9 then assaulted R8 who suffered a humerus and femur fracture. Staff had knowledge of and failed to identify, report, investigate allegation after R9 disclosed alleged sexual abuse by an unknown perpetrator to E11 Licensed Practical Nurse (LPN). The facility subsequently failed to report to the State Survey Agency. R7, R8, R9, R10, R14 and R15 are six of eight residents reviewed for abuse in the sample of eighty nine. These failures have the potential to affect all 145 residents residing in the facility.	This REQUIREMENT is not met as evidenced by: A. Based on interview and record review, the facility failed to operationalize their policy to effectively identify, report and protect R7 from possible abuse when physical restraint was applied against her (R7) wishes. The alleged perpetrators had continued access to all residents. The facility failed to identify tailed to protect R8 from R9 after an incident where R9 had thrown coffee at three other residents (R10, R14 and R15) in the dining room. R9 then assaulted R8 who suffered a humerus and femur fracture. Staff had knowledge of and failed to identify this incident as a possible allegation of abuse, failed to report and investigate. The facility failed to identify, report and protect R7 from possible abuse when physical restraint was applied against her (R7) wishes. The alleged perpetrators had continued access to all residents. The facility failed to protect R8 from R9 after an incident where R9 had thrown coffee at three other residents (R10, R14 and R15) in the dining room. R9 then assaulted R8 who suffered a humerus and femur fracture. Staff had knowledge of and failed to identify this incident as a possible allegation of abuse, failed to report and investigate. The facility failed to identify, report, investigate and provide protection after R9 disclosed alleged sexual abuse by an unknown perpetrator to E11 Licensed Practical Nurse (LPN). The facility subsequently failed to report to the State Survey Agency. R7, R8, R9, R10, R14 and R15 are six of eight residents reviewed for abuse in the sample of eighty nine. These failures have the potential to affect all 145 residents residing in the facility.	This REQUIREMENT is not met as evidenced by: A. Based on interview and record review, the facility failed to operationalize their policy to the State Survey Agency. The facility failed to identify, report and continued access to all residents. The facility failed to protect R8 from R9 after an incident where R9 had thrown coffee at three other residents (R10, R14 and R15) in the dining room. R9 then assaulted R8 who suffered a humerus and femur fracture. Staff had knowledge of and failed to identify, report, investigate and provide protection after R9 disclosed alleged sexual abuse by an unknown perpetrator to E11 Licensed Practical Nurse (LPN). The facility subsequently failed to report to the State Survey Agency, R7, R8, R9, R10, R14 and R15 are six of eight residents reviewed for abuse in the sample of eighty nine. These failures have the potential to affect all 145 residents reviewed for abuse in the sample of eighty nine. These failures have the potential to affect all 145 residents re	This REQUIREMENT is not met as evidenced by: A. Based on interview and record review, the facility failed to identify, report and prossible abuse when physical restraint was applied against her (R7) wishes. The facility failed to identify this incident as a possible allegations of abuse failed to report and investigate. The facility failed to identify this incident as a possible allegation of abuse, failed to report and investigate. The facility salied to identify, report, investigate and protection after R9 disclosed alleged sexual abuse by an unknown perpetrator to It 1 Licensed Practical Nurse (LPN). The facility salied to affect all 145 residents reviewed for abuse in the sample of eighty nine. These failures have the potential to affect all 145 residents reviewed for abuse in the facility.	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 20.22			С	
		145584	B. WING		10	/03/2014	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
PALM TE	ERRACE OF MATTOO	N		1000 PALM MATTOON, IL 61938			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		HOULD BE	(X5) COMPLETION DATE		
F 226	Program" dated 11. employees "report suspicion of potent misappropriation of about, or suspect to immediate supervision the administrator inform the administrator, the pof all reports, incide potential abuse, ne property. Upon lear administrator, or in administrator the poshall initiate an inci investigationRe another resident wi with other resident wi with other residents investigation. The ashall be immediate most suitable thera placement, consider as the safety of oth the facilityEmplo been accused of misappropriation of immediately remove the results of the inreviewed by the ad External Reporting facility must ensure involving mistreatmincluding injuries of misappropriation of reasonable suspicific immediately to the to other officials in	ditiled "Abuse Prevention (11/11, documents that all any incident, allegation or ial abuse, neglect or property they observe, hear of the administrator or an sor who must then report it to Supervisors shall immediately trator or in the absence of the person in charge of the facility, ents, allegations or suspicion of glect or misappropriation of ming of the report, the the absence of the erson in charge of the facility, dent sidents who allegedly mistreat all be removed from contact and during the course of the excused resident's condition ally evaluated to determine the py, care approaches and ering his or her safety, as well er residents and employees of yees of the facility who have istreatment, neglect, abuse or residents property will be ed from resident contact until vestigation have been ministrator or designee. of Potential Abuse, The ethat all alleged violations tent, neglect or abuse,	F 2	226			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
		145584	B. WING			C 02/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 PALM	1 10/	03/2014
				MATTOON, IL 61938		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 226	bodily injury or susp the report shall be renforcement agency. Survey Agency imm suspicion (but no la forming the suspicion must be made not forming the suspicion. The suspicion of the suspicion. The suspicion of the suspicion of the suspicion. The suspicion of the suspicion of the suspicion of the suspicion of the suspicion. The suspicion of t	able suspicion result in serious pected criminal sexual abuse, made to at least one law by of jurisdiction and the State nediately after forming the atter than two hours after on), Otherwise, the report later than 24 hours after on." Order Sheet (POS) dated cuments diagnoses of a with associated Dementia Anxiety, Depression, Muscle	F 2	226		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (Y1) PROVIDED (STATEMENT OF DEFICIENCIES (Y1) PROVIDED (STATEMENT)

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ELE CONSTRUCTION	COMPLETED		
		145584	B. WING		10/0	3/2014
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP C 1000 PALM MATTOON, IL 61938		•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 226	(R7) that (R7) was stay there." On 9/23/14 at 4:38 to bed and got on wanted a (disposal she could go (urina to (R7) continu of bed and on the wheel chair, she (Fwhen we brought honcoming nurse is the arms of the who was bucking a forwardI wanted dignity while I gave Nurse) report. I to me with the sheet. her she needed to to the bathroom arput her in bed, oncreport and did som and (R7) was still i down." On 9/25/14 at 8:05 he received in report and put R7 at the rishe doesn't fall. On 9/24/14 at 8:25 scared then (9/5/14) the same nurse (Enight. (E17) kept to wanted to go to the underpants and hawhen the nurse (Enot wear that diaped)	age 27 already in bed and wouldn't pm, E17 stated " (R7) was put her call light constantly. (R7) ble incontinence brief) on so ate) in her bed if she wanted ed restless, trying to climb out call light. We got her up in the R7) had on a hospital gown on her to the nurses station. The male so I tied the bed sheet to eel chair to cover the resident and thrusting her pelvis d her (R7) covered for her own e (E14, Licensed Practical ld (E18) to come over and help I'm talking to (R7) telling calm down. We would take her nytime she needed to go and e she was calm. I finished he paper work, left a little late on the chair and had not calmed am E14 stated that on 9/5/14 but from E17 that E17 got R7 up hurses station to watch her so am, R7 stated "I was really 4) and again last night, that's 17) who was working that elling me I was bad because I elling me I was bad because I elling the light would er (E17) and (E18) tied the he back of my wheelchair.	F 226			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		145584	B. WING _		10	C / 03/2014	
	PROVIDER OR SUPPLIER	N	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 PALM MATTOON, IL 61938				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 226	They (E17 and E18 did it." " (E17) would wheel chair so I find myself, then (E18) let me go to bed."	don't like me that's why they dn't take it (bed sheet) off my ally got the sheet untied took me to the bathroom and	F 2	26			
	at the nurses statio wanted to go to bed She(R7) is a fall risher (R7) up and brobecause she kept twas yelling she war and E18) told her (I we'd put her in bed on one side of the version	pm E18 stated " (R7) was up n hollering and yelling that she d but she wouldn't stay in bed. Sk that's why second shift got bught her to the nurses station rying to get out of bed. (R7) nted to go to bed. We (E17 R7)when she calmed down Then (E17) tied the sheet wheel chair arm and I (E18) is bar in front of the wheel chair					
	Nurse (LPN) stated Certified Nursing A: E17 had tied R7 in 9/5/14. E21 reporte	pm, E21, Licensed Practical I that on 9/7/14 night shift E19, ssistant (CNA) told E21 that the wheelchair with a sheet on d this to E20, Assistant (ADON) 9/8/14 at 6:00 am.					
	reported the allegat	5 am, E20 stated that she tion to E2, Director of Nursing ame in the morning of 9/8/14.					
	thought it (tying the was for R7's dignity	O am, E2 stated that she bed sheet to the wheel chair) and confirmed this with E17 14. " I did not view this as					
		am, E1, Administrator stated " f Nursing did not view this					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		145584	B. WING				03/ 2014
	PROVIDER OR SUPPLIER	N		10	REET ADDRESS, CITY, STATE, ZIP CODE 100 PALM ATTOON, IL 61938		,
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	abuse. I was informinvestigated it as all been interpreted as Nurse/Certified Nurdocuments that on before an investigated to work before and during trestrained with a beperpetrators, E17ar access to all reside initiated 9/9/14. The Investigation F State Survey Agence 9/19/14 at 12:08 pm 9/5/14 2. R9's Admission Ass 11/6/13 documents. R9's Admission Ass 11/6/13 documents physical violence at harm. There was R9's physical aggree R9's Physician Ord 9/30/14 documents Depression and Blich R9's Minimum Data documents a Brief (BIMS) of 11/15 (m 9/25/14 at 9:22 am.)	estrained with a bed sheet) as ned on 9/9/14, reported and buse because it could have a abuse." The facility raing Assistant (CNA) schedule 9/8/14, E17 continued to work tion was initiated. E18 9/8/14, 9/9/14 and 9/10/14 he investigation into R7 being ed sheet. The alleged and E18 had unrestricted ants until the investigation was deport documents that the cy was not notified until an of the incident that occurred ease Sheet is dated 11/06/14 sessment for Violence dated that R9 has had a history of and the physical ability to cause no documented evidence of ession toward others on file.	F 2	226			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145584	B. WING _		10	C 0/ 03/2014
	PROVIDER OR SUPPLIER	N		STREET ADDRESS, CITY, STATE, ZIP COI 1000 PALM MATTOON, IL 61938		5/05/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 226	R9's Facility Nursin Registered Nurse (5:00 pm document room and drinking coffee across the roback to his room af residents were comwet." R9's Facility Nursin Registered Nurse (6:00 pm document push another residents another residents Registered Nurse (7:00 pm document as (R9) wanted to for 10 pm document as (R9) sair took him to his room hands. He (R9) sair R9 remained in his continued with dining room who cup hit me and the and R15). Then (R15 sue me." On 9/25/14 at 9:40 my table when (R9) hit (R10 and R14). I hadn't been leaving the room and R15 in t	g Notes, signed by E12, RN) and dated 9/19/14 at "resident was in the dining coffee. He (R9) flung his comResident was helped fer this incident as other aplaining about being made g Notes, signed by E12, RN) and dated 9/19/14 at " (R9) was seen by staff to ent (R8) from the next room." g Notes, signed by E12, RN) and dated 9/19/14 at (R9) asked where (R8) was ight (R9). pm, E15 Certified Nursing ated "(R9) spilt his coffee and I m too helped him wash his d he was going to take a nap." room while other residents and. am, R10 stated "I was out in en (R9) threw his coffee. The coffee landed on them (R14 9) said I threw the coffee, so	F 22	26		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CC	(X3) DATE SURVEY COMPLETED			
		145584	B. WING				C / 03/2014
	PROVIDER OR SUPPLIER	L		1000	PALM FOON, IL 61938	<u> 10</u>	100/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 226	yelling help, help, hhis hot cup of coffedirectly at me. Hot arm. Three CNA Strunning. Then anot room." The Investigation F coffee on 9/19/14 a in Nurses Notes 9/of the alleged abus reported to the E1, Agency or investigation.	elp to the staff as (R9) raised e, aimed at me and threw it coffee got all down my left aff (unknown names) came her CNA (E15) took (R9) to his deport documents R9 threw at 5:00 pm. (E12 documented 19/14 that he had knowledge se). This allegation was not Administrator, State Survey ated until the surveyor reported e E1, Administrator on 9/25/14	*	226			
	9/30/14 documents Depression and Bli R9's Minimum Data documents a Brief (BIMS) of 11/15 (m 9/25/14 at 9:22 am is cognitively intact he is doing." R9's Facility Nursin Licensed Practical 8/22/14 at 5:45 am began yelling and s (R9) complained th yelling started when anyone he touched tell." On 9/24/14 at 11:57	order Sheet dated 9/1/14 - diagnoses of Schizophrenia, andness. A Set (MDS) dated 7/21/14 Interview for Mental Status ild cognitive impairment). On 22, Psychiatrist stated " (R9) He (R9) is very aware of what g Notes, signed by E11, Nurse (LPN) and dated documents that " resident slamming doors at 5:15 am at man touched my penis, the note that man told me not to tell my penis, but I am going to graph of am E11 stated "(R9) said the old him not to tell anyone that a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		145584	B. WING				C 03/2014
	PROVIDER OR SUPPLIER			10	TREET ADDRESS, CITY, STATE, ZIP CODE DOO PALM IATTOON, IL 61938	10/	55/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	he (R9) said regardereferred to the man on 9/24/14 at 4:55 remember anybod recently but it has I want to say about The Investigation in State Survey Agen 9/23/14 at 4:13 pm 8/22/14. The same police department pm. Facility Data Sheet census of 145. B. Based on intervifacility failed to form recognize the need to local law enforce R8 and R9 are two abuse in the samp Findings include: R9's Admission Far R9's Admission Far R9's Admission Far R9's Physician Orce 9/30/14 documents Depression and BI diagnoses of Schizelian Control of Schizelian Con	ding his penis because he in the mirror." If pm R9 stated "I can't y trying to touch my penis happened in the past. That's all that." Report documents that the locy was not notified until of the incident that occurred export documents the local was notified 9/23/14 at 7:00 It dated 9/11/14 documents a iew and record review, the masuspicion of a crime and doto report as a possible crime ement when R9 assaulted R8. To residents of eight reviewed for alle of eighty nine. Indee Sheet is dated 11/06/13. The second of the composition of the	F2	226			
		sessment for violence dated sthat R9 has had a history of					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (V41) PROVIDED (SUBDILITATION AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		145584	B. WING _		10	C / 03/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 1000 PALM MATTOON, IL 61938		70072011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 226	physical violence a harm. There is no physical aggressio R9's Minimum Dat documents a Brief (BIMS) of 11/15 (m MDS dated 7/17/14/15 (no cognitive 9:22 am, Z2, Psyc cognitively intact. In the is doing." " (R8) not aware of any ir other residents." R9's Nursing Notes Nurse (RN) and documents " (R9) another resident (FOn 9/23/14 at 2:38 Assistant (CNA) stillew across the roc side." On 9/24/14 at 2:30 to the floor Stat (im floor. I knew right a broken, it was rota complained of pair told me that (R8) in (which is connecte yelling about it whe (E10) told me (R8) on his right side." On 9/24/14 at 1:20 worked the night (FON 18/14/14) at 1:20 wor	and the physical ability to cause documented evidence of R9's n toward others on file. a Set (MDS) dated 7/21/14 Interview for Mental Status illd cognitive impairment). R8's 4 documents a BIMS score of e impairment). On 9/25/14 at chiatrist stated " (R9) is He (R9) is very aware of what is cognitively intact and I am indication of aggression towards as, signed by E12, Registered ated 9/19/14 at 6:00 pm was seen by (E10) staff to push		26		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		145584	B. WING		1	C 0/03/2014
	PROVIDER OR SUPPLIER	N		STREET ADDRESS, CITY, STATE, ZIP C 1000 PALM MATTOON, IL 61938	•	0/00/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 226	(R9) kept saying I was on the floor in lage was on the floor in lage tyelling. I could another (E15)CNA on 9/24/14 at 5:45 night since I've bee the bathroom to R9 nights (R9) wakes ryellingNow I know of, it's not just (R9) (R9)can physically to fear him because The Emergency Row 8:17 pm documents fracture and a right admitted the hospit The Emergency Row 7:33 pm documents right posterior trape another resident (Rom 9-24-14 at 2:30 the facility and placunder one to one surface on 9/23/14 at 2:38 my nurse (E12) rigwas a crime, the account of the police on 9/24/14 at 8:00 I did not view that (I situation as a crime	vant to fight him (R8)R8 his (R8) room and (R9) just hit calm him (R9) down so came to help me." pm, R8 stated " about every in in this room (connected by s'room) every couple of me up slamming doors and w what he's (R9) is capable threatening me now he nurt me again. I can't continue of this assault." om Note dated 9/19/14 at s R8 suffered a right femur humerus fracture and was al for surgical repair. om Note dated 9/19/14 at s that R9 was treated for a sizius strain after he punched 8) at the facility. E12 stated o.m. that R9 was returned to ed on a behavioral care unit	F 2	26		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145584	B. WING _			C / 03/2014
	PROVIDER OR SUPPLIER	N		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 PALM MATTOON, IL 61938		03/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 279 SS=D	On 9/24/14 at 2:30 stated "I did not rep I viewed this incider altercation. I reported Administrator) right outside of here to massault and a crime The Investigation Repolice department of 4:15 pm. The Facility Policy, Potential Abuse state all alleged violate neglect or abuse, in source, misappropring reasonable suspicion immediately to the atto other officials in a through established caused the reasonabodily injury or suspite report shall be reforcement agency Survey Agency immediately to the atto other officials in a through established caused the reasonabodily injury or suspite report shall be reforcement agency Survey Agency immediately to the atto other officials in a through established caused the reasonabodily injury or suspite report shall be reforcement agency agency immediately forming the suspicion (but no la forming the suspicion (pm E12 Registered Nurse port this to the police because in as just a resident to resident ed to (E26, Assistant away. If this had happened in a live of the live of live of the live of the live of live of the live of live of the live of live of live of the live of li	F 22			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION ()		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C	
		145584	B. WING _			03/2014
NAME OF PROVIDER OR SUPPLIER PALM TERRACE OF MATTOON				STREET ADDRESS, CITY, STATE, ZIP CODE 1000 PALM MATTOON, IL 61938	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 279	objectives and time medical, nursing, a needs that are iden assessment. The care plan must to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident' §483.10, including tunder §483.10, including tunder §483.10(b)(4) This REQUIREMENT by: Based on observative review, the facility for comprehensive car interventions to additional to aggressive three residents revion the care plan in Findings include: R9's Admission Ass 11/6/13 documents physical violence at harm. There is no physical aggression R9's Physician Ord	ent that includes measurable etables to meet a resident's and mental and psychosocial tified in the comprehensive at describe the services that are attain or maintain the resident's physical, mental, and being as required under ervices that would otherwise \$483.25 but are not provided as exercise of rights under the right to refuse treatment entering the right to refuse treatment. NT is not met as evidenced attent to develop a e plan with safety dress R9's propensity for behavioral issues. R9 is one of ewed for changes in condition the sample of eighty nine. Sessment for Violence dated that R9 has had a history of and the physical ability to cause documented evidence of R9's in toward others on file. er Sheet dated 9/1/14 - diagnoses of Schizophrenia,	F 27	9		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
		145584	B. WING				C 03/2014
NAME OF PROVIDER OR SUPPLIER PALM TERRACE OF MATTOON				1000	PALM TOON, IL 61938	1 10/	03/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 279	R9's Minimum Data documents a Brief (BIMS) of 11/15 (m 9/25/14 at 9:22 am is cognitively intact he is doing."	a Set (MDS) dated 7/21/14 Interview for Mental Status ild cognitive impairment). On , Z2, Psychiatrist stated " (R9) He (R9) is very aware of what	F 2	79			
	Nurse (RN) and dadocument "resident drinking coffee. He the roomReside	s, signed by E12, Registered ated 9/19/14 at 5:00 pm and was in the dining room and (R9) flung his coffee across ent was helped back to his dent as other residents were being made wet."					
	Nurse (RN) and da document " (R9) wa	s, signed by E12, Registered ated 9/19/14 at 6:00 pm as seen by staff to push 8) from the next room."					
	Nurse (RN) and da	s, signed by E12, Registered ated 9/19/14 at 7:00 pm ed where (R8) was as (R9)					
	the dining room wh cup hit me and the	am, R10 stated "I was out in en (R9) threw his coffee. The coffee landed on them (R14 9) said "I threw the coffee, so					
	my table when (R9)	am, R15 stated "I was leaving threw the cup of coffee and I was in a direct line to be hit if g the table."					
	yelling help, help, h	pm, R14 stated " I started elp to the staff as (R9) raised e, aimed at me and threw it					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	DATE SURVEY COMPLETED
		145584	B. WING	_		C 1 0/03/2014
NAME OF PROVIDER OR SUPPLIER PALM TERRACE OF MATTOON			STREET ADDRESS, CITY, STATE, ZIP CODI 1000 PALM MATTOON, IL 61938	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE
F 279	arm. Three (Certific Staff (unknown nan another CNA (E15)) R9's Nursing Notes Nurse (RN) and da documents "(R9) wanother resident (R) On 9/23/14 at 2:38 push (R8). (R8) flev on his right side." On 9/24/14 at 2:30 to the floor Stat (im floor. I knew right a broken, it was rotat complained of pain told me that (R8) no (which is connected yelling about it whe (E10) told me (R8) on his right side." On 9/24/14 at 1:20 worked the night (Fusually calm (R9) do (R9) kept saying I was on the floor in kept yelling. I could another (E15)CNA On 9/24/14 at 5:45 night since I've beet the bathroom to R9 nights (R9) wakes it yellingNow I know	coffee got all down my left ed Nurse Assistants) CNA' mes) came running. Then took (R9) to his room." s, signed by E12, Registered ted 9/19/14 at 6:00 pm vas seen by (E10) staff to push 88)." pm, E10 stated "I saw (R9) w across the room and landed pm, E12 stated "I was called mediately), (R8) was on the tway that his (R8) leg was ted outward and he in his leg and shoulder. (E10) eeded to use the bathroom d to R9's room) they were en (E10) saw (R9) push (R8). flew across the room landing pm, E25 CNA stated " I R9) pushed (R8) down. I can down but not that night. He want to fight him (R8)R8 his (R8) room and (R9) just lin't calm him (R9) down so	F 2	2.79		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (V41) PROVIDED (SUBDILITATION AND HUMAN SERVICES

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		145584	B. WING			C 03/2014
NAME OF PROVIDER OR SUPPLIER PALM TERRACE OF MATTOON				STREET ADDRESS, CITY, STATE, ZIP CODE 1000 PALM MATTOON, IL 61938	1 10	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
F 279	The Emergency Ro 8:17 pm document fracture and a right admitted the hospi The Emergency Ro 7:33 pm document right posterior trape another resident (Fon 9-24-14 at 2:30 the facility and place under one to one see	hurt me again. I can't continue e of this assault." Dom Note dated 9/19/14 at s R8 suffered a right femur thumerus fracture and was tal for surgical repair. Dom Note dated 9/19/14 at s that R9 was treated for a ezius strain after he punched R8) at the facility. E12 stated p.m. that R9 was returned to sed on a behavioral care unit	F 27	9		
	problem statement documented on ad of violent physical not updated to refleon 9/19/14. On 9/24/14 at 7:57 Director) stated " I should be more sp pretty much explain specific as they protect the statement of the Facility Policy Care Planning, uncomprehensively as	red 7/17/14 documents no or interventions were mission related to R9's history behaviors. R9's care plan was ect R9's aggressive behaviors am E30 (Social Service can see the behavior tracking ecific, it's vague for sure. That his why the care plans aren't as abably should be." Comprehensive Assessment / dated documents "to ssess, in a timely manner, dmission. The results of this				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145584	B. WING		1	C 0/ 03/2014
NAME OF PROVIDER OR SUPPLIER PALM TERRACE OF MATTOON				STREET ADDRESS, CITY, STATE, ZIP COL 1000 PALM MATTOON, IL 61938		0/03/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 279		_	F 2'	79		