STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145503	A. BUILDING _____ B. WING _____	C 07/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS REHABILITATION & CARE CENTER	**3516 POWELL LANE MATTOON, IL 61938**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	FINAL OBSERVATIONS Section 300.610 a)The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder . These written policies shall be followed in operating the facility and shall be reviewed at	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145503	A. BUILDING _____ B. WING _____	C 07/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS REHABILITATION & CARE CENTER	**3516 POWELL LANE MATTOON, IL 61938**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 7 least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. c)These written policies shall include, at a minimum the following provisions: 2) Resident care services including physician services, emergency services, personal care and nursing services, restorative services, activity services, pharmaceutical services, dietary services, social services, clinical records, dental services, and diagnostic service (including laboratory and x-ray). Section 300.1030 a) The advisory physician or medical advisory committee shall develop policies and procedures to be followed during the various medical emergencies that may occur from time to time in long-term care facilities. These medical emergencies include, but are not limited to, such things as: 1) Pulmonary emergencies (for example, airway obstruction, foreign body aspiration, and acute respiratory distress, failure, or arrest). 2) Cardiac emergencies (for example, ischemic pain, cardiac failure, or cardiac arrest). c) There shall be at least one staff person on duty at all times who has been properly trained to handle the medical emergencies in subsection (a) of this Section. This staff person may also be conducted in fulfilling the requirement of subsection (d) of this Section, if the staff person meets the specified certification requirements. d) When two or more staff are on duty in the facility, at least two staff people on duty in the facility shall have current certification in the provision of basic life support by an American	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145503	A. BUILDING _____ B. WING _____	C 07/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS REHABILITATION & CARE CENTER	**3516 POWELL LANE MATTOON, IL 61938**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 8 Heart Association or American Red Cross certified training program. When there is only one person on duty in the facility, that person needs to be certified. Any facility employee who is on duty in the facility may be utilized to meet this requirement. Section 300.1210 a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) Based on interview and record review the facility failed to initiate emergency procedures for one of one residents (R3) found non-responsive. The facility also failed to assure that 17 Certified	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145503	A. BUILDING _____ B. WING _____	C 07/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS REHABILITATION & CARE CENTER	**3516 POWELL LANE MATTOON, IL 61938**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 9 Nursing Assistants (CNA) out of 33, and 3 of 14 nurses on staff were current in Cardiopulmonary Resuscitation Certification (CPR) although facility expectations were that all would be certified. Findings include: R3's most recent Physician's Order Sheet dated July of 2005 showed R3 was diagnosed with Hypertension and Paranoid Schizophrenia. The Physician's Order Sheet also showed R3 is a " Full Code" and CPR should be initiated. R3's clinical record "face sheet" showed R3 was a 58 year old resident admitted to this facility on May 14, 2005. A document with the facility's letterhead and titled "Comprehensive Checklist For Compliance With The Patient Self- Determination Act of OBRA (Office of Budget and Management Reconciliation Act) 1990" indicated R3 was a full code. R3's chart showed a green, full page Advance Directive Sheet that stated "(R3) is a Full Code..." This sheet is dated 5/13/05 and signed by E13 the Social Service Director. Nurses notes dated July 4, 2005 at 4:50 AM showed R3 was found at approximately this time on July 4th, 2005 non-responsive by E6, a Certified Nurses Assistant. The note states, " CNA reported resident (R3) (not) breathing. Observed (resident's) skin cold mottled (no) respirations, (no) pulse - res chart revealed Full Code CPR (and) rescue breathing initiated (with) Ambu - bag - call placed to 911." Interview with E4 LPN (the only nurse on duty at	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145503	A. BUILDING _____ B. WING _____	C 07/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS REHABILITATION & CARE CENTER	**3516 POWELL LANE MATTOON, IL 61938**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 10	F9999		

the time of the incident) on 7/14/05 at approximately 2:40 PM showed she was made aware that R3 was found non-responsive and after initially examining R3, turned the emergency care over to the two CNAs (E5 and E6). E4 stated, "...(E6) came and told me that she thought (R3) was dead. I grabbed my stethoscope and ran to (R3's) room. Her face was bluish grey, she was not breathing and she did not have a pulse. I ran to the chart and checked to see that (R3) was a full code. Then I called to (E5, CNA) we need you... We (both E4, Charge Nurse and E5,) ran to (R3's) room... I handed the Ambu Bag to (E6), I said start CPR and I called 911. I did not stay in the room, I went to make phone calls and to let the emergency people in..."

Facility document titled "Employee Report" dated 7/19/05 and signed by the Administrator and witnessed by the Director of Nurses (DON) stated, " (E4 LPN), failed to follow proper procedure at the time a resident was found who appeared to have expired. Policy is to properly initiate CPR, regardless of the circumstances. Errors were made in the CPR procedure which were the responsibility of (E4)."

Interview with the Assistant Administrator, E1 on 7/14/05 at approximately 11:00 AM showed the licensed nurse (who did have valid CPR certification) left two CNA's (who did not have valid CPR certification) alone to attempt to resuscitate R3. E1 confirmed the LPN acted improperly in leaving the scene of the resuscitation efforts.

Interview with E6 (CNA) on 7/15/05 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145503	A. BUILDING _____ B. WING _____	C 07/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS REHABILITATION & CARE CENTER	**3516 POWELL LANE MATTOON, IL 61938**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 11 approximately 10:00 AM indicated that she was left with another CNA (E5), by the Charge Nurse, in R3's room to handle the emergency resuscitation efforts. E6 stated, "...on my final round I found (R3) non-responsive...I shook her and hollered her name. (I picked up her arm) her arm was limp, it slid out of my hand and fell away . Her head moved when I moved her hand and (her head) fell back to where it was. I could see her face was discolored. She was very limber at that time. I looked at her face and at her chest, she was not breathing - her skin was cool to the touch. I left the room - the call light was hooked to the bed. I went to get the nurse...I told her to come here - (E4 Charge Nurse) and I went to (R3 's) room...(E4) listened to her (R3's) chest, I think she felt for a pulse - (E4) touched (R3's) skin with her hand. (E4) said she was going to check the chart to see if (R3) was a full code - if so she was going to call 911 and she said she would be back . I don't know how long she was gone. When she came back, she brought back the Ambu Bag. She gave it to me and told me to use it until the rescue people get here, and that's what I did. I put the mask on her (R3's) face and I squeezed the bag. I did not observe her chest rise or fall. I don't know if I repositioned her head or not. I never did see her chest rise or fall. No one did chest compressions and I don't remember anyone saying anything about chest compressions. After (E4 Charge Nurse) brought the bag (Ambu Bag) in she said either bag her or do CPR, I don't remember. (E4) then left the room, she may have said she was going to let the rescue people in - after she brought the bag and left - I was wondering where she went to...I have not had CPR training this year, I believe my card is expired."	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145503	A. BUILDING _____ B. WING _____	C 07/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS REHABILITATION & CARE CENTER	**3516 POWELL LANE MATTOON, IL 61938**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 12 Interview with E5, CNA on 7/15/05 at approximately 9:15 AM showed she was in R3's room with E6 and that the nurse E4, did not lead resuscitation efforts or take control of the situation. E5 stated, "It was around 5:00 AM when I heard (E4) the nurse call my name and tell me to get to ... - (E6) CNA was already in the room and (E4 Charge Nurse) arrived just a few steps ahead of me...(E4) told (E6) to bag resident and (E6) proceeded to do it - it was chaotic and (E4) was running back and forth and yelling. (E4) seemed out of control. I never saw (E4) touch (R 3). I made the comment to her (E4) to calm down . She (E4) was saying 'you don't understand, you don't understand. She was out of control, really out of control. But I did not start compressions. No one did compressions while I was in the room . My CPR card is expired..." Interview on 7/15/05 at 1:30 p.m. with Z1, Facility Medical Director and personal Physician to R3, stated that full Cardiopulmonary Resuscitation should have been done on R3. The doctor stated "...short of full rigor (Rigor Mortis) I would do CPR and then worry about how much time had passed . (If you are going to error) error on the conservative side..." The Physician also verified that R3 did not have any terminal diagnoses. The doctor stated, "She (R3) had no cardiac arrhythmias nor any congestive heart failure, nothing that suggested imminent death." Facility listing of all CPR certified personnel documents that 3 of 14 nurses on the nursing staff and 17 of 33 Certified Nurses Assistants did not have up-to-date CPR certification. Interview with the DON on 7/19/05 at approximately 2:00	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145503	A. BUILDING _____ B. WING _____	C 07/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS REHABILITATION & CARE CENTER	**3516 POWELL LANE MATTOON, IL 61938**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 13 PM confirmed these numbers were correct. Interview with the DON on 7/19/05 at approximately 2:00 PM indicated she expected all nursing staff (including CNAs) to be certified in CPR.	F9999		