STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145757	A. BUILDING _____ B. WING _____	C 08/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE REHAB & SKILLED CARE	120 NORTH TOWER ROAD CARBONDALE, IL 62901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 323	Continued From page 8 9. A fall shift report was initiated to make sure the staff were aware of residents affected. Completed 08-22-07. 10. The facility DON and or designee will review the shift report, accident and incident report and fall assessment daily to continue monitoring residents that are high risk for falls to be able to provide safety and supervision to the identified residents. Completed on 08-23-07 and will be ongoing.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)3)6) 300.1220b)7) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145757	A. BUILDING _____ B. WING _____	C 08/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE REHAB & SKILLED CARE	120 NORTH TOWER ROAD CARBONDALE, IL 62901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	F9999		

further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.
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 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
7) Coordinating the care and services provided to residents in the nursing facility.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These Requirements are not met as evidenced by:

Based on interview and record review the facility failed to provide adequate supervision, implement effective interventions and investigate patterns and causes of falls for one of five sampled residents, R2, with a history of frequent falls. The facility identified 41 current residents as being at high risk for falls. R2 was left unsupervised on 08-18-07 at 4:50 AM during an episode of restlessness and attempting to get out of the wheel chair. R2 fell striking her head resulting in fractures of the first and second cervical discs of the spine. The fractures suffered by R2 on 08-18-07 resulted in her death.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145757	A. BUILDING _____ B. WING _____	C 08/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE REHAB & SKILLED CARE	120 NORTH TOWER ROAD CARBONDALE, IL 62901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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		

Findings Include:

Review of the facility admission sheet shows R2 was admitted to the facility on 02-23-07 with a diagnosis that includes Seizure Disorder and Renal Failure. Per review of the Minimum Data Set (MDS) completed by staff on 04-27-07, R2 was alert and orientated with periods of confusion. A plan of care dated 05-20-07 verifies this information. Review of the facility's accident and incident logs for the months of March to August of 2007 shows R2 suffered falls on 14 different occasions. The falls occurred as follows
1. On March 12, R2 fell without noted injury. The intervention listed by staff after the fall was to review R2's lab results with the physician.
2. On April 28, R2 fell without injury. The intervention for this fall was for staff to reorientate R2 to the use of the call light.
3. In May, R2 fell six different times, on 05-01, 05-07, 05-12, 05-18, 05-23 and 05-30. The fall on 05-01-07 resulted in R2 being transferred to a local hospital for x-rays of her head and shoulder due to complaints of pain after the fall. No fracture was found. The interventions listed on the log and care plan to prevent falls for May were, 05-01-07, a wheel chair alarm when in the dining room, 05-07-07, removal of the wheel chair foot rests. On 05-18-07, lower the seat of the wheel chair and continue with Occupational Therapy. On 05-23-07, move to a room that is more visible and apply a wedge raised cushion in the wheel chair.
4. In June, R2 fell five times. The falls occurred on 06-02, 06-07 (Two falls were noted; one at 2:45 PM and again at 8:30 PM), 06-08 and 06-25. The fall on 06-25 resulted in an abrasion to the bridge of R2's nose. Four of R2's falls in June occurred in the resident's room, even though R2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145757	A. BUILDING _____ B. WING _____	C 08/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE REHAB & SKILLED CARE	120 NORTH TOWER ROAD CARBONDALE, IL 62901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	F9999		

had been moved to a more visible room after the multiple falls recorded in May. The interventions listed on the log and care plan for the June falls were on 06-02-07 place the alarm where R2 cannot reach it, and on 06-08-07 R2 was to wear hipsters at all times. There was no indication that the facility initiated effective interventions regarding R2's falls. The times, location and possible causes were not taken into consideration to prevent the reoccurrence of the falls.

Review of nurses notes on 08-18-07 that are timed for 5:40 AM shows a CNA (E9) had gotten R2 out of bed and put her in a wheel chair at approximately 4:50 AM. R2 kept trying to get out of bed and causing the bed alarm to go off. Per the note, R2 was also trying to get out of the wheel chair after she was up causing the alarm to go off. Interview with E9 by phone on 08-22-07 at 1:10 PM, R2 had been very restless during the early morning hours of 08-18-07. R2 attempted to get out of bed several times, so E9 got her up and sat her in a wheel chair with an alarm in the chair. E9 stated that the wheel chair had foot pedals on it, but did not have any type of cushion in the seat. E9 also stated that she was the only staff member on the south wing at 4:50 AM. E9 said that she heard another alarm going off down the hallway and had to respond to it, leaving R2 alone. E9 said that she had not been gone long when she heard R2's alarm going off again and responded to it as fast as she could. E9 found R2 on the floor with lacerations to the front and back of her head and bleeding badly from the lacerations. E9 said that she went to the north wing to call the nurse over to evaluate R2. E9 was asked if R2 had a history of falls and E9 replied that she did not know. She did know that the alarm was supposed to be on R2 at all times and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145757	A. BUILDING _____ B. WING _____	C 08/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE REHAB & SKILLED CARE	120 NORTH TOWER ROAD CARBONDALE, IL 62901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	F9999		

stated incorrectly that the foot pedals were to be in place at all times. E9 was not aware of a seat cushion of any type for R2 and stated that there was no cushion in the wheel chair when she placed R2 in it. On the day of the exit E1 stated that supervisors had spoken with E9 and the employee had remembered that a cushion had been in place in R2's wheelchair. E1 stated that E9 did not understand what a pommel cushion was and had responded no when asked if it had been in the chair.

Review of the nursing notes dated 08-18-07 shows R2 was transferred to a local hospital for evaluation of her injuries. At 10:00 AM on 08-18-07 the nursing notes state that the local hospital contacted the facility to inform them that R2 was being transferred to a hospital in St. Louis to be evaluated by a Neuro-surgeon. On 08-20-07 at 2:45 PM, nursing notes state that the facility was contacted by a case manager from the hospital in St. Louis to inform them that R2 had passed away.

Per interview with Z2 (physician at St. Louis Hospital) by phone on 08-23-07 at approximately 10:00 AM, R2 had suffered two fractured vertebrae at the levels of C1 and C2 as a result of the fall on 08-18-07 and the fractures were the cause of her death.

(A)