STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007983	A. BUILDING: _____ B. WING _____	03/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM HC & REHAB CTR OF CAHOKIA	3354 JEROME LANE CAHOKIA, IL 62206

(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) COMPLETE DATE
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS 300.610a) 300.1210a) 300.1210b)5) 300.1210d)6) 300.1220b)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007983	A. BUILDING: _____ B. WING _____	03/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM HC & REHAB CTR OF CAHOKIA	3354 JEROME LANE CAHOKIA, IL 62206

(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) COMPLETE DATE
S9999	Continued From page 1 allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall 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 resident care plan. 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. Restorative measures shall include, at a minimum, the following procedures: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. d) Pursuant to subsection (a), 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.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007983	A. BUILDING: _____ B. WING _____	03/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM HC & REHAB CTR OF CAHOKIA	3354 JEROME LANE CAHOKIA, IL 62206

(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) COMPLETE DATE
S9999	Continued From page 2 Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements are not met as evidenced by: Based on observation, interview and record review, the Facility failed to implement progressive interventions to prevent falls for three of six residents (R1, R10, R17) reviewed for falls in a sample 24. This failure resulted in R1 falling and being hospitalized with a right hip fracture. This failure also resulted in R10 falling and being hospitalized with a left femoral neck fracture. Findings include:	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007983	A. BUILDING: _____ B. WING _____	03/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM HC & REHAB CTR OF CAHOKIA	3354 JEROME LANE CAHOKIA, IL 62206

(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) COMPLETE DATE
S9999	Continued From page 3	S9999		

1. The Facility's Unusual Occurrence Tracking Log documents falls for R10 on 8/6/13, 8/17/13, 8/18/2013, 1/16/14, 2/10/14. R10's Incident Investigation for the fall on 2/22/14 documents the fall resulted in a fracture of the left femoral neck.

On 3/20/14 at 9:30 AM, E9 and E12, both Certified Nurse Aides (CNA's), transferred R10 from his wheelchair to his bed. They explained the procedure, applied the gait belt and asked for R10 to stand for the transfer. R10's legs were bent during transfer, he did not support his weight or follow directions to stand.

The Incident Investigations for R10, dated 1/16/14, 2/10/14, and 2/22/14, all document unwitnessed falls in his room with statements from R10 that he fell while trying to self transfer. The Report for the fall on 2/22/14 at 2:30 PM also documents, R10 was observed on the floor next the the bed. The 2/22/14 radiology report confirms R10 sustained a fracture of the left femoral neck. He was sent to the hospital for treatment.

At 3/20/14 at 12:30 PM, an interview was conducted with E14 Licensed Practical Nurse (LPN) Minimum Data Set (MDS) Coordinator. E14 explained she assesses each resident for fall risk upon admission to the Facility, quarterly and on significant change. R10's Fall Assessment did not have a score or value to explain his risk level. E14 explained she just uses her opinion about the "risk level" for falls based on each individual's diagnosis list and the level of mobility.

R10's Quarterly MDS, dated 11/11/13, and Significant Change MDS, dated 1/9/14, document R10 is severely cognitively impaired. Both MDS's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007983	A. BUILDING: _____ B. WING _____	03/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM HC & REHAB CTR OF CAHOKIA	3354 JEROME LANE CAHOKIA, IL 62206

(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) COMPLETE DATE
S9999	Continued From page 4	S9999		

document R10 requires extensive assist with transferring, bathing, toileting, hygiene and his balance is such that he cannot stabilize himself without staff support and he does not ambulate.

R10's Quarterly Care Plan for 11/11/13, Significant Change Care Plan for 1/9/14 and Re-entry/Significant Change Care Plan for 2/26/14 have no documentation of new safety interventions after each fall. Interventions included: 8/6/13 alarm added to R10's bed; 8/17/13 added to R10's wheelchair; 8/18/13 R10 placed on the "Orange Fall Program". The safety interventions for falls on 1/16/14 and 2/10/14 were updated dates for alarms on bed and wheelchair.

The Facility's undated Think Orange Policy documents (in part), "All residents with orange name tags are a fall risk. They (the residents) cannot be left alone while in their rooms. They will be encouraged to attend activities of choice or will be closely monitored in the common areas."

2. The Incident Investigations for R1, dated 9/13/13, 11/16/13, and 11/23/13, all document unwitnessed falls in his room with statements from R1 that he fell while trying to put himself to bed. R1's fall on 11/23/13 resulted in R1 being hospitalized with a right hip fracture.

R1's 11/5/13 MDS, documents (in part): R1 requires extensive assistance of 2 persons to transfer and to ambulate.

R1's Falls Care Plan, last revised on 11/23/13, documents (in part): "(R1) is high risk for falls due to his Dx (diagnosis) of Dementia and his past history of frequent falls. (R1) is not safe to transfer on his own but make frequent attempts to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007983	A. BUILDING: _____ B. WING _____	03/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM HC & REHAB CTR OF CAHOKIA	3354 JEROME LANE CAHOKIA, IL 62206

(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) COMPLETE DATE
S9999	Continued From page 5	S9999		

do so. Interventions: 5/7/10 Initiate orange card program for fall prevention."

In an interview on 3/25/14 at 2:00 PM, E2, Director of Nurses (DON), stated, "He (R1) is on the Orange Card Program which is they aren't supposed to be left in their rooms alone. He (R1) is one who finishes his meal quickly. Then (R1) wants to go smoke, but he must be supervised for smoking. If he (R1) can't smoke, then he is ready to go to bed. He (R1) can propel himself in the wheelchair and takes himself to his room. For those falls in November (2013), he (R1) shouldn't have been in his room unsupervised and he tried to put himself to bed."

3. On 03/20/2014 at 12:10 PM, R17 was sitting in wheel chair in dining room awaiting lunch.

On 03/21/2014 at 10:25 AM, R17 was wheeling herself down the hallway.

The 01/10/14 at 6:30 AM Facility Incident Investigation Report, documents R17 was found sitting on her buttocks on floor. R17 had been walking throughout the facility with a wheeled walker. R17 was not injured in this fall. The facility ordered a chest X-ray for R17. R17 was found to to have pneumonia and an antibiotic was ordered.

On 01/14/2014 at 1:45 PM, the Facility Incident Investigation Report , Documents R17 was found lying on her back in the whirlpool room. R17 ambulated with her wheeled walker. An injury was not documented. The Facility documented that an oxygen saturation should be done on her three times daily.

On 01/19/2014 at 7:00 PM, R17's Facility Incident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007983	A. BUILDING: _____ B. WING _____	03/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM HC & REHAB CTR OF CAHOKIA	3354 JEROME LANE CAHOKIA, IL 62206

(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) COMPLETE DATE
S9999	Continued From page 6	S9999		

Investigation Report documents R17 was found on the floor in front of dietary office on the east wing. R17 was not using her wheeled walker. R17 complained of shoulder pain, but an injury was not documented. The facility ordered a reevaluation of her gait and walker safety per Restorative Therapy.

On 01/22/2014 at 9:30 PM, the Facility Incident Investigation Report documents R17 was found on the floor in the central hallway. An injury was not documented. The Facility ordered Physical therapy to evaluate and treat R17.

On 01/31/2014 at 2:30 PM The Facility Incident Investigation Report documents R17 fell on her bottom ,while trying to seat herself in the dining room. An injury was not documented. The facility ordered the Activity Department to monitor R17, while she is in the dining room.

On 02/02/14 at 6:20 AM The Facility Incident Investigation Report documents R17 fell, while trying to seat self in the dining room. A small abrasion was on R17's forehead. The Facility ordered a wheelchair to be used, whenever the R17 feels weak. A personal alarm was added to the wheel chair.

On 03/21/2014 at 1:05 PM E 5 Licensed Practical Nurse (LPN) was interviewed concerning where oxygen saturation results are found. E5 stated "they are found on the computer."

On 03/21/2014 at 1:15 PM E6 LPN was interviewed concerning the restorative and walker safety evaluation that was ordered per the Facility. E6 stated "a functional balance exam was done to see whether R17 could stand or not,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007983	A. BUILDING: _____ B. WING _____	03/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM HC & REHAB CTR OF CAHOKIA	3354 JEROME LANE CAHOKIA, IL 62206

(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) COMPLETE DATE
S9999	Continued From page 7 but that is all I did." On 03/21/2014 at 1:10 PM E7, Activity Director, was asked if they monitored R17 for falls during meals. E7 stated "the activity department makes sure R17 has a seat in the dining room, and gives R17 a wet wipe as she leaves the dining room." On 03/21/2014 After reviewing the Care Plan interventions, for the falls dated 01/10/2014 through 02/02/2014. 01/10/2014 obtain a chest X-ray, 01/14/2014 monitor oxygen saturations three times daily, 01/19/2014 restorative is to evaluate gait and walker safety, 01/22/2014 skilled therapy to evaluate R17 ,1/31/2014 R17 is to remain with activities during mealtimes. As documented above three of these interventions were not implemented per staff. (B)	S9999		