| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 145316 | A. BUILDING _____ B. WING _____ | C 11/01/2006 |

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| **EMBASSY HEALTH CARE CENTER** | **555 WEST KAHLER WILMINGTON, IL 60481** |

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| F 000 | INITIAL COMMENTS<br><br>Investigation of Complaint #0674348/IL25440<br>#0674364/IL25456<br><br>F324 applies to both complaints.<br><br>A Partial Extended Survey was conducted. | F 000 | | |
| F 324 SS=K | 483.25(h)(2) ACCIDENTS<br><br>The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on Record Review, Interview and Observation, the facility failed to supervise 5 of 5 residents surveyed (R1, R2,R3, R4, R5) that were identified and/or met the criteria of being at a "High Risk" for falls. This failure resulted in; R1 sustained a subluxation of the cervical spine at the C4-C5 level with spinal cord injury and was non-responsive on a ventilator in the intensive care unit of the hospital, R2 sustained a fracture of the right hip requiring surgical intervention, R3 sustained a fracture of the right hip requiring surgical intervention, R4 sustained numerous bruises and abrasions from repeated falls, R5 sustained bruises, hematomas and a laceration requiring emergency room treatment. These failures to supervise residents resulted in an immediate jeopardy that began on 9/30/06.<br><br>Findings include:<br><br>The record of R1, a 67 year old female with | F 324 | | 11/20/06 |

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

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| F 324 | Continued From page 1<br>diagnoses of Parkinson's Disease, Ulcers, Recurrent Urinary Tract Infection, Schizoaffective Disorder and Altered Mental Status was reviewed on 10-20-06.<br>R1's record contains a "Fall Risk Assessment" dated 9/20/06 with a score of 16. According to the "Fall Risk Assessment" a total score of 10 or above represents "High Risk."<br>R1's record contains a care plan dated 9/12/06 which states, "Resident has a greater than normal risk for falls." Interventions on the care plan dated 9/21/06 include "lap buddy when in a wheelchair and provide ambulation and exercise."<br><br>R1's record contains the following nursing documentation; on 9/30/06 at 7PM "Resident found on floor...large hematoma noted to left side of head. Laceration 3 centimeters(cm) long and 1 cm wide noted to forehead with slight bleeding noted pack applied...Orders received to transfer to ...emergency room.", on 10/6/06 at 7 AM, "Certified Nurse Assistant (CNA) stated resident fell back and ....red areas on right back and right arm...transferred to the emergency room (ER).",on 10/7/06 at 5PM, "Resident fell to floor in bathroom. Has 2 hematomas to back of head with abrasions. Alert.....5:20 PM Resident in wheelchair with body alarm attached.", on 10/10/06 at 3:15 PM, "Resident fell forward out of chair onto the floor, no injury noted. Assisted to bed.", on 10/16/06 at 4:10 PM, Found resident lying on mattress with wheelchair lying on top of her with lap buddy and body alarm in place...", on 10/17/06 at 12:15AM, "Resident found on floor in room on right side holding left forehead. Large hematoma noted to left forehead. Large abrasion to right side of knee...1:00 PM Ambulance here resident transported to emergency room." | F 324 | | |

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| F 324 | Continued From page 2<br><br>An incident/accident report dated 9/30/06 for R1 lacks interventions for preventing falls that were in use prior to the fall and interventions planned to prevent further falls. An incident/accident report for R1 dated 10/4/06 states, "resident slipped out of wheelchair...in front hallway." This report lacks interventions currently in use to prevent falls and interventions planned to prevent further falls. An incident/accident report for R1 dated 10/6/06 states, "patient fell back and hit back of head and back", the report lacks documentation of the interventions used to prevent falls before the fall occurred and what changes in interventions were made after the fall." An incident/accident report for R1 dated 10/10/06 states, "Resident sitting in wheelchair. Fell forward out of wheelchair onto floor." This report lacked documentation of interventions in use to prevent falls prior to the this fall and interventions planned to prevent falls in the future. An incident/accident report for R1 dated 10/16/06 stated that R1,"fell forward onto mattress(low bed) with the lap buddy in place and the wheelchair on top of her." This report lacked documentation of the interventions planned to prevent further falls. An incident accident report for R1 dated 10/17/06 states that, "Resident TABS alarm sounding. Nurse immediately responded. Resident found on floor on right side. Hematoma to left side of forehead. Large reddened area and abrasion to right knee..."<br><br>The emergency medical system's "Run Sheet" contained the following documentation, "Upon arrival at skilled nursing facility patient found in bed in fetal position. RN states patient increasingly lethargic, patient not responsive." The hospital's "Report of Consultation"dated | F 324 | | |

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| F 324 | Continued From page 3<br>10/17/06, contains documentation that R1 has "severe dehydration with hyponatremia, seizures most likely secondary to hyponatremia, subluxation of the C4- C5 vertebrae(per CT scan), patient is unresponsive...bruising is noted in the right knee calf region and lower extremity as well." Emergency room notes for R1 contains documentation that, "Patient has impaction (fecal) that has been digitally removed per RN to obtain a rectal temperature...seizure activity noted." The hospital record contained a physician progress note that states, "Respiratory failure secondary to multiple problems, ... dehydration..."<br><br>On 10/20/06 R1 was observed in the intensive care unit of the hospital. R1 was intubated and ventilator dependant for respirations. R1 had multiple bruising to the face, neck and lower extremities. R1 had a large hematoma to the left side of the head and the back of the neck. R1 was not responsive to verbal or tactile stimuli at that time. R1 was not moving her extremities. A urinary drainage bag noted as well as a nasogastric tube drain ing bile colored fluid. R1 was receiving intravenous fluids and antibiotics.<br><br>In an interview on 10/20/06 at 10:00 AM with E2, the Assistant Administrator, she stated that, "I did not know about the falls of R1 until the resident went out to the emergency room on 10/17/06. The Licensed Practical Nurse (LPN) E2, who was caring for R1 told me she started neuro checks and R1 was unchanged cognitively after the fall. E2 told me she paged the physician after R1 fell but he did not call back." In an interview with E1, the Administrator on 10/20/06 at 9:45 AM, she stated that E7, the LPN was "suspended pending the completion of the investigation of R1's fall | F 324 | | |

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| F 324 | Continued From page 4<br>and she saw R1 the morning after the fall and she seemed fine." In an interview with E4, a Certified Nurse Assistant (CNA), she stated on the morning after the fall R1 was, "fine, she was uncooperative as usual but she ate her breakfast." E4 also stated R1 had, "bruises on the back of her neck and had a black eye." E4 stated R1 was, "moving all her extremities and babbling."<br><br>In an interview with Z1, a nurse case manager at the hospital where R1 is being cared for, she stated the hospital received R1 unresponsive, had to have an external pacemaker, was intubated and placed on a ventilator for respiratory distress and had seizures. Z1 stated R1 had a large hematoma on the left side of her head, a hematoma at the base of the back of her neck and bruising to her lower extremities.<br><br>In an interview with E5, the owner, he stated E7, the LPN who cared for R1, was terminated.<br><br>The record of R2, an 85 year old female, was admitted to the facility with diagnoses of Hypertension, GERD, Dementia, Depression and post fracture of left hip, was reviewed on survey dates 10/20/06 and 10/30/06. The record of R2 contained a Fall Risk Assessment dated 4/24/06 which stated R2 was not at risk for falls. However, R2 had a history of a hip fracture. R2's record contained nursing documentation dated 10/10/06 the stated, "Ambulating in hall. Tripped and fell. Left leg shortening and external rotation. Complains of extreme pain...Ambulance here." R2's record contained a discharge plan from the hospital dated 10/17/06 that contained documentation the R2 had a left hip fracture with surgical intervention. An incident /accident report | F 324 | | |

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| F 324 | Continued From page 5<br>dated 10/22/06 stated that R2, "...tried to get back into bed and fell on the floor." R2's incident/ accident report lacked the interventions to prevent falls in use at the time of the fall and lacked planned interventions to prevent falls in the future.<br><br>The record of R3, an 83 year old female admitted to the facility with diagnoses of Fracture Left Hip, Chronic Obstructive Pulmonary Disease, Hypothyroidism, Dementia and Lymphoma, was reviewed on 10/20/06 and 10/30/06. R3's record contained a "Fall Risk Assessment" that scored R3 at 11 which represents "High Risk" R3's record contains nursing documentation dated 10/11/06 at 1:15 AM that states, "Resident found on floor in middle of front hallway on her right side...Resident was able to move all extremities." R3's record contained nursing documentation dated 10/12/06 that states, "No ill effects from fall of 10/11..." R3's record contains nursing documentation dated 10/13/06,at 4:30 PM "...Xray to right hip done..." R3 subsequently went to the emergency room of the hospital. A consultation report from the hospital states, "an accidental fall and resultant right femoral neck fracture" R3 had surgical intervention for the hip fracture. R3's record contained documentation R3 fell previously and sustained a fracture of the left wrist. R3's record lacked documentation of a fall care plan, investigation of R3's falls with injuries and interventions to prevent falls in the future.<br><br>The record of R4, a 62 year old male admitted to the facility with diagnoses of Dementia, Seizure disorder, Hypothyroidism, and Parkinson's Disease was reviewed on 10/30/06. R4's record contains nursing documentation of 13 incidents of | F 324 | | |

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| F 324 | Continued From page 6<br>falls between 8/06 and 10/22/06. R4 sustained varying degrees of injury ranging from bruises to abrasions. All except one of the incident/accident reports for R4 for the months of August, September and October lacked documentation of what interventions were currently utilized to prevent R4 from falling and what interventions were planned to prevent him from falling in the future.<br><br>The record of R5, a 26 year old female admitted to the facility with diagnoses of Seizures and Mental Retardation was reviewed on 10/30/06. R5's record contained documentation of 6 falls between 9/7/06 and 10/19/06. R5's record contains documentation that R5 wears a padded helmet due to seizures and falls, however the record lacks a "Fall Risk Assessment." R5's record lacked documentation of a comprehensive plan to prevent future injuries due to seizures and falls.<br><br>Facility policy titled, "Facility Policy Regarding Resident Falls" requires that, "...it is this facility's policy to act in a proactive manner to identify and assess those residents at risk for falls, plan for preventive strategies and facilitate as safe an environment as possible. All resident falls will be assessed and the resident's existing plan of care will be evaluated for needed changes...Each resident fall shall be documented in the resident's clinical record." The facility failed to follow their policy regarding falls as evidenced above.<br><br>E5 and E1 were notified on 10/30/06 at 8:45 AM of an Immediate Jeopardy related to falls. While the Immediate Jeopardy was removed on 10/30/06, the facility remains out of compliance at a severity level two. Additional time is needed to | F 324 | | |

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| F 324 | Continued From page 7<br>monitor and evaluate the effectiveness of the revised policies and procedures to ensure their implementation.<br><br>Surveyor confirmed that the facility took the following actions to remove the immediate jeopardy:<br><br>1. All residents are being evaluated for falls and a new fall risk assessment is being done.<br>2. All resident's assessments as a high fall risk will have care plan added.<br>3. All staff will be in-serviced on how to monitor high-risk residents. Content including: monitoring falls, nutrition, offering of fluids, UTI's, constipation, CNA tracking forms and anticipation of resident needs.<br>4. A QA evaluation for the last 3 months to determine what shift has the most problems with falls and what staff need additional in-service training.<br>5. Additional in-service education on completing incident/accident reports to include what interventions are in use, in what order, complete assessments and outcome of event.<br>6. All charts will be reviewed for fall assessments to ensure completion<br>7. All care Plans will be reviewed for all high-risk residents to ensure completion.<br>8. QA sheets (fall tracking) will remain to ensure all interventions are done<br>9. Incidents/accidents will be addressed on a daily basis by interdisciplinary team.<br>10. Fluids accessible at all times.<br>11. All policies will be reviewed and updated as needed. | F 324 | | |
| F9999 | FINAL OBSERVATIONS | F9999 | | |

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| F9999 | Continued From page 8<br>LICENSURE VIOLATIONS<br><br>Section 300.610a)<br>Section 300.1210a)<br>Section 300.1210b)6)<br><br>Section 300.610 Resident Care Policies<br>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 least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br>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. Restorative measures shall include at a minimum the following procedures:<br>b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:<br>6) All necessary precautions shall be taken to | F9999 | | |

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| F9999 | Continued From page 9<br>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.<br><br>These requirements were not met as evidenced by:<br><br>Based on Record Review, Interview and Observation, the facility failed to supervise 5 of 5 residents surveyed (R1, R2, R3, R4, R5) that were identified and/or met the criteria of being at a "High Risk" for falls. This failure resulted in: R1 sustained a subluxation of the cervical spine at the C4-C5 level with spinal cord injury and was non-responsive on a ventilator in the intensive care unit of the hospital, R2 sustained a fracture of the right hip requiring surgical intervention, R3 sustained a fracture of the right hip requiring surgical intervention, R4 sustained numerous bruises and abrasions from repeated falls, and R5 sustained bruises, hematomas and a laceration requiring emergency room treatment.<br><br>Findings include:<br><br>1. The record of R1, a 67 year old female with diagnoses of Parkinson's Disease, Ulcers, Recurrent Urinary Tract Infection, Schizoaffective Disorder and Altered Mental Status was reviewed on 10-20-06. R1's record contains a "Fall Risk Assessment" dated 9/20/06 with a score of 16. According to the "Fall Risk Assessment" a total score of 10 or above represents "High Risk."<br><br>R1's record contains a care plan dated 9/12/06 which states, "Resident has a greater than normal risk for falls." Interventions on the care | F9999 | | |

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| F9999 | Continued From page 10<br>plan dated 9/21/06 include "lap buddy when in a wheelchair and provide ambulation and exercise."<br><br>R1's record contains the following nursing documentation relating to falls:<br>9/30/06 at 7:00 PM, "Resident found on floor...large hematoma noted to left side of head. Laceration 3 centimeters(cm) long and 1 cm wide noted to forehead with slight bleeding noted pack applied...Orders received to transfer to ...emergency room."<br>10/6/06 at 7:00 AM, "Certified Nurse Assistant (CNA) stated resident fell back and ....red areas on right back and right arm...transferred to the emergency room (ER)."<br>10/7/06 at 5:00 PM, "Resident fell to floor in bathroom. Has 2 hematomas to back of head with abrasions. Alert.....5:20 PM Resident in wheelchair with body alarm attached."<br>10/10/06 at 3:15 PM, "Resident fell forward out of chair onto the floor, no injury noted. Assisted to bed."<br>10/16/06 at 4:10 PM, "Found resident lying on mattress with wheelchair lying on top of her with lap buddy and body alarm in place...."<br>10/17/06 at 12:15AM, "Resident found on floor in room on right side holding left forehead. Large hematoma noted to left forehead. Large abrasion to right side of knee...1:00 PM Ambulance here resident transported to emergency room."<br><br>An incident/accident report dated 9/30/06 for R1 lacks interventions for preventing falls that were in use prior to the fall, and interventions planned to prevent further falls. An incident/accident report for R1 dated 10/4/06 states, "resident slipped out of wheelchair...in front hallway." This report lacks interventions currently in use to | F9999 | | |

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| F9999 | Continued From page 11<br>prevent falls, and interventions planned to prevent further falls. An incident/accident report for R1 dated 10/6/06 states, "patient fell back and hit back of head and back." The report lacks documentation of the interventions used to prevent falls before the fall occurred, and what changes in interventions were made after the fall." An incident/accident report for R1 dated 10/10/06 states, "Resident sitting in wheelchair. Fell forward out of wheelchair onto floor." This report lacks documentation of interventions in use to prevent falls prior to the this fall, and interventions planned to prevent falls in the future. An incident/accident report for R1 dated 10/16/06 stated that R1, "fell forward onto mattress(low bed) with the lap buddy in place and the wheelchair on top of her." This report lacks documentation of the interventions planned to prevent further falls. An incident accident report for R1 dated 10/17/06 states that, "Resident TABS alarm sounding. Nurse immediately responded. Resident found on floor on right side. Hematoma to left side of forehead. Large reddened area and abrasion to right knee...."<br><br>The emergency medical system's "Run Sheet" contained the following documentation, "Upon arrival at skilled nursing facility patient found in bed in fetal position. RN states patient increasingly lethargic, patient not responsive." The hospital's "Report of Consultation," dated 10/17/06, contains documentation that R1 has "severe dehydration with hyponatremia, seizures most likely secondary to hyponatremia, subluxation of the C4- C5 vertebrae (per CT scan), patient is unresponsive...bruising is noted in the right knee calf region and lower extremity as well." Emergency room notes for R1 contain documentation that, "Patient has impaction | F9999 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 145316 | A. BUILDING _____ B. WING _____ | C 11/01/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **EMBASSY HEALTH CARE CENTER** | **555 WEST KAHLER WILMINGTON, IL 60481** |

| (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 |
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| F9999 | Continued From page 12<br>(fecal) that has been digitally removed per RN to obtain a rectal temperature...seizure activity noted." The hospital record contained a physician progress note that states, "Respiratory failure secondary to multiple problems, ... dehydration...."<br><br>On 10/20/06 R1 was observed in the intensive care unit of the hospital. R1 was intubated and ventilator dependant for respirations. R1 had multiple bruising to the face, neck and lower extremities. R1 had a large hematoma to the left side of the head and the back of the neck. R1 was not responsive to verbal or tactile stimuli at that time. R1 was not moving her extremities. A urinary drainage bag was noted as well as a nasogastric tube draining bile colored fluid. R1 was receiving intravenous fluids and antibiotics.<br><br>In an interview on 10/20/06 at 10:00 AM with E2, the Assistant Administrator, she stated that, "I did not know about the falls of R1 until the resident went out to the emergency room on 10/17/06. The Licensed Practical Nurse (LPN), E2, who was caring for R1 told me she started neuro checks and R1 was unchanged cognitively after the fall. E2 told me she paged the physician after R1 fell but he did not call back." In an interview with E1, the Administrator, on 10/20/06 at 9:45 AM, she stated that E7, the LPN, was "suspended pending the completion of the investigation of R1's fall, and she saw R1 the morning after the fall and she seemed fine." In an interview with E4, a Certified Nurse Assistant (CNA), she stated on the morning after the fall R1 was, "fine, she was uncooperative as usual but she ate her breakfast." E4 also stated R1 had, "bruises on the back of her neck and had a black eye." E4 stated R1 was, "moving all her | F9999 | | |

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| F9999 | Continued From page 13<br>extremities and babbling."<br><br>In an interview with Z1, a nurse case manager at the hospital where R1 is receiving care, she stated the hospital received R1 unresponsive, had to have an external pacemaker, was intubated and placed on a ventilator for respiratory distress and had seizures. Z1 stated R1 had a large hematoma on the left side of her head, a hematoma at the base of the back of her neck and bruising to her lower extremities.<br><br>In an interview with E5, the facility's owner, he stated E7, the LPN who cared for R1, was terminated.<br><br>2. The record of R2, an 85 year old female who was admitted to the facility with diagnoses of Hypertension, GERD, Dementia, Depression and post fracture of left hip, was reviewed on survey dates 10/20/06 and 10/30/06. The record of R2 contained a Fall Risk Assessment dated 4/24/06 which stated R2 was not at risk for falls. However, R2 had a history of a hip fracture. R2's record contained nursing documentation dated 10/10/06 that stated, "Ambulating in hall. Tripped and fell. Left leg shortening and external rotation. Complains of extreme pain...Ambulance here." R2's record contained a discharge plan from the hospital dated 10/17/06 that contained documentation that R2 had a left hip fracture with surgical intervention. An incident/accident report dated 10/22/06 stated that R2, "...tried to get back into bed and fell on the floor." R2's incident/ accident report lacked the interventions to prevent falls in use at the time of the fall, and lacked planned interventions to prevent falls in the future. | F9999 | | |

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| F9999 | Continued From page 14<br>3. The record of R3, an 83 year old female admitted to the facility with diagnoses of Fracture Left Hip, Chronic Obstructive Pulmonary Disease, Hypothyroidism, Dementia and Lymphoma, was reviewed on 10/20/06 and 10/30/06. R3's record contained a "Fall Risk Assessment" that scored R3 at 11 which represents "High Risk." R3's record contains nursing documentation dated 10/11/06 at 1:15 AM that states, "Resident found on floor in middle of front hallway on her right side...Resident was able to move all extremities." R3's record contained nursing documentation dated 10/12/06 that states, "No ill effects from fall of 10/11...." R3's record contains nursing documentation dated 10/13/06,at 4:30 PM "...Xray to right hip done...." R3 subsequently went to the emergency room of the hospital. A consultation report from the hospital states, "an accidental fall and resultant right femoral neck fracture." R3 had surgical intervention for the hip fracture. R3's record contained documentation R3 fell previously and sustained a fracture of the left wrist. R3's record lacked documentation of a fall care plan, investigation of R3's falls with injuries, and interventions to prevent falls in the future.<br><br>4. The record of R4, a 62 year old male admitted to the facility with diagnoses of Dementia, Seizure disorder, Hypothyroidism, and Parkinson's Disease was reviewed on 10/30/06. R4's record contains nursing documentation of 13 incidents of falls between 8/06 and 10/22/06. R4 sustained varying degrees of injury ranging from bruises to abrasions. All except one of the incident/accident reports for R4 for the months of August, September and October lacked documentation of what interventions were currently utilized to prevent R4 from falling and | F9999 | | |

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| F9999 | Continued From page 15<br>what interventions were planned to prevent him from falling in the future.<br><br>5. The record of R5, a 26 year old female admitted to the facility with diagnoses of Seizures and Mental Retardation was reviewed on 10/30/06. R5's record contains documentation of 6 falls between 9/7/06 and 10/19/06. R5's record contains documentation that R5 wears a padded helmet due to seizures and falls, however the record lacks a "Fall Risk Assessment." R5's record lacked documentation of a comprehensive plan to prevent future injuries due to seizures and falls.<br><br>6. Facility policy titled, "Facility Policy Regarding Resident Falls" requires that, "...it is this facility's policy to act in a proactive manner to identify and assess those residents at risk for falls, plan for preventive strategies and facilitate as safe an environment as possible. All resident falls will be assessed and the resident's existing plan of care will be evaluated for needed changes... Each resident fall shall be documented in the resident's clinical record." The facility failed to follow their policy regarding falls as evidenced above.<br><br>(A) | F9999 | | |