STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	LTIPLE CONSTRUCTION		DATE SURVEY COMPLETED	
7 II D I D II O O O O II I O O O O O O O		IDENTIFICATION NOMBER.	A. BUILDING		C		
		145343	B. WING	3		1/2008	
NAME OF PROVIDER OR SUPPLIER  AMBASSADOR NURSING CENTER		S	STREET ADDRESS, CITY, STATE, ZIP CODE 4900 NORTH BERNARD CHICAGO, IL 60625				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	the smoking policy. completed by the D that staff are follow Random audits will Services to monitor residents have ciga The QA Committee Medical Director wi until resolution. In a psychological risks	Random audits will be PON or Designee to monitor ing the smoking policy. be completed by Social that only designated arettes or smoking utensils. It under the guidance of the lil review all identified trends addition any medical and will be reviewed for by the Medical Director as	F 32	23			
F9999	a) The facility must and services to atta practicable physica well-being of the reeach resident's complan of care. Adequation of care and peto each resident to personal care need b) General nursing minimum the follow a 24-hour, seven description.	ATIONS:  General Requirements for nal Care  provide the necessary care ain or maintain the highest I, mental, and psychological sident, in accordance with aprehensive assessment and late and properly supervised ersonal care shall be provided meet the total nursing and is of the resident.  care shall include at a ring and shall be practiced on	F999	99			

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		145343	B. WIN	IG _			C <b>1/2008</b>
NAME OF PROVIDER OR SUPPLIER  AMBASSADOR NURSING CENTER				4	REET ADDRESS, CITY, STATE, ZIP CODE 900 NORTH BERNARD CHICAGO, IL 60625		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F9999	as free of accident nursing personnel sthat each resident rand assistance to personnel strate and assistance to person services  b) The DON shall sursing services of 2) Overseeing the other esidents' need defined conditions as sensory and physic status and requirent discharge potential potential, rehabilitar and drug therapy. 3) Developing an uffor each resident becomprehensive assand goals to be accorders, and person Personnel, represenursing, activities, of modalities as are of be involved in the person plan. The plan shall reviewed and modineeded as indicated the plan shall be remonths.  Section 300.3240 Arabi and An owner, licens	dents' environment remains hazards as possible. All shall evaluate residents to see eccives adequate supervision prevent accidents.  Supervision of Nursing  upervise and oversee the the facility, including: comprehensive assessment of s, which include medically and medical functional status, al impairments, nutritional nents, psychosocial status, dental condition, activities tion potential, cognitive status, p-to-date resident care plan ased on the resident's complished, physician's all care and nursing needs. Inting other services such as dietary, and such other redered by the physician, shall preparation of the resident care and the resident care and the physician of the physic	F99	999			

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		145343	B. WIN	1G _			C <b>1/2008</b>	
NAME OF PROVIDER OR SUPPLIER  AMBASSADOR NURSING CENTER			•	4	REET ADDRESS, CITY, STATE, ZIP CODE 1900 NORTH BERNARD CHICAGO, IL 60625			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F9999	Continued From pa	ige 7	F99	999				
	by: Based on record re	eview and interview, the facility one resident (R1) who was						
	diagnosed with der and psychosis/seiz identified as needir	nentia, history of depression ure disorder. R1 was ng supervision to smoke. This resulted in R1 catching on fire						
	Findings include:							
	went out to the faci staff. R1 was trying lighter and caught I residents on the pa	en 5:40 AM and 6:00 AM, R1 lity patio unsupervised by to light a cigarette with a nimself on fire. There were two tio with R1 during this incident area was unsupervised by staff ent.						
	investigation, R3 re responding she wa all agencies. R2 wa AM. R2 responded smoking. R1 and R no staff on the patic when I heard R3 ye around and R1 was a lighter. His sleeve blanket she had an She could not do it still trying to light hi became fully engul realized he was on screaming after both	tnesses. At the time of efused to be interviewed, so tired of being interviewed by as interviewed 1/2/08 at 11:40 she was on the pation. Were with her. There were on "I was facing the street ell that R1 was on fire. I turned so trying to light a cigarette with ewas on fire. R3 took and tried to put his sleeve out.  I R2 responded that R1 was so cigarette after this and fed in flames before he fire. He then started th R2 and R3 yelled to R1 that and R3 went into the facility						

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		145343	B. WIN	G			C 1/2008
NAME OF PROVIDER OR SUPPLIER  AMBASSADOR NURSING CENTER			•	49	EET ADDRESS, CITY, STATE, ZIP CODE 000 NORTH BERNARD HICAGO, IL 60625		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			(X5) COMPLETION DATE
F9999	through the patio dowas on fire. E6 residoor and put R1 out fire department can E4 was interviewed was with R1 before R1 12/28/07 at 5:40 smoking area. He rasked me if he couwith him and gave smoked the cigaret dining room togethe came into the dining were talking. E6 the with R4 . E6 and Rand then came bad in the dining room. room and went out time myself (E4) and 2nd floor. I came bad dining room when I door yelling fire. I we could not get through stated it was the chourning and putting ran back up the stayelled fire to the 2n ran down from the extinguisher. She reout with the fire ext arrived. (E8 dialed fire at the time I we Records were reviered.)	oor. R2 and R3 yelled that R1 conded by going out the patio at with a fire extinguisher. The ne."  I on 1/2/08 at 10:30 AM. E4 the incident. "I went out with 0 AM to the outside patio net me in the dining room and 1d smoke. I went to the patio nim a cigarette. I also lit it. We tes and we returned to the er through the patio door. R2 groom and the three of us en came into the dining room 4 went to the patio to smoke k into the facility. R1 was still R2 then came into the dining to smoke in the patio. At this id E6 went up the stairs to the fack down to the 1st floor R2 came through the patio ent to the patio door and gh because of the flames. (E4 air outside the door that was a flames in front of the door.) I irs to pull the fire alarm. I d floor nurse. At this time E6 2nd floor with a fire an out to the patio and put R1 inguisher. The fire department 1911 when I yelled there was a not to pull the alarm).	F99	99			

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		145343	B. WIN	IG _			C 1/2008
NAME OF PROVIDER OR SUPPLIER  AMBASSADOR NURSING CENTER			•	49	EET ADDRESS, CITY, STATE, ZIP CODE 900 NORTH BERNARD HICAGO, IL 60625		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	R1 was forgetful. E supervision to smo cigarettes from the would not be given have to light the cigarea.  E3 (Social Service stated that R1 was his room or the bui supervised smokinskills, and he would sitting in his chair. Were reviewed. Nor R1 was reminded the know when he smoked the cigarette and sismoke.  R1's care plan date compliant smoker. Cigarette burns were Smoking risk asses 5/30/07 shows R1 Smoking Safety Risrequires supervision 11/20/07 states R1 dated 11/20/07 shows two classification. The smoking policy has two classification in the go to the "Supervision" state	or) was interviewed. E7 stated 7 stated that R1 required ke. R1 would be given two 3rd floor nurses station. He matches. The staff would garette for him in the smoking worker) was interviewed. E3 compliant with not smoking in ding, but he was placed on g because of his cognitive d sometimes fall asleep when social Service Progress notes that he needs to let the staff whee so staff can be with him. O7 show that when R1 go to the administrator to get waff has to be with him to ad 11/07 states R1 is a The same note shows that the found in R1's clothes. Soment dated on 3/5/07 and required supervision to smoke. Sk Assessment states that R1 in. The smokers list dated requires supervision. The list was R1 requires supervision. One is son" which states that a sc cigarette and light from staff designated area to smoke. It is that the resident has to get the from staff and then go to	F99	999			

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		145343	B. WING			C <b>02/11/2008</b>	
NAME OF PROVIDER OR SUPPLIER  AMBASSADOR NURSING CENTER			•	49	EET ADDRESS, CITY, STATE, ZIP CODE 00 NORTH BERNARD HICAGO, IL 60625		
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F9999	the designated area classifications of suresident is to carry on "Supervision" peduring the investiga 12/03 and 12/04/07  The police report d 12/07/07, show that R1 was taken to the The Fire Department the source of fire wighter or the cigare determined during and residues as a second sec	a with a staff to smoke. Both apervision state that no matches or a lighter. R1 was er social service notes found ation. These notes were dated 7.  atted as completed on this was an accidental death. The hospital in critical condition. In the report dated 12/28/07 show as a lighter. The source of the ette that R1 had could not be this investigation. None of the interviewed knew the source of	F99	99			