STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145343	A. BUILDING _____ B. WING _____	C 07/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBASSADOR NURSING & REHAB CENTER	**4900 NORTH BERNARD CHICAGO, IL 60625**

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F 312	Continued From page 8 During 6/23/10 interview at 2 PM, E10 said that when she came in there were no pads or sheets from laundry. E10 added that it probably was around 10:15 AM when the supplies came in, thus R3 was changed around that time. E10 also said that it took her time to take care of the resident in one room because the other resident had some unusual bleeding issues. E10 said she had no sheets and pads that she could use for R3. E10 said that the nurse helps out all the time but on 6/23/10, there were just no supplies from laundry. E10 said that when she changed R3's diaper, it was just soaked with urine, not stool.	F 312		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210a) 300.3240a) 300.3240b) 300.3240d) 300.3240e) 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility. These written policies shall be followed in operating the facility. 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 psychosocial well-being of the resident, in accordance with	F9999		

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F9999	Continued From page 9 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act) e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) These Requirements were not met as evidenced by: Based on interview and record review, the facility failed to ensure that residents on the 1st floor of the facility are protected from a staff (E3) immediately after she was witnessed slapping	F9999		

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F9999	Continued From page 10	F9999		

and choking 1 resident (R3) in the sample of 5. E3 was allowed to sit at the first floor nurses station where she had the potential to have contact with residents on the first floor, and those coming out of the 1st floor elevator which is directly in front of the 1st floor nurses station. E3 was also left by E4 (nurse) who was attending to another resident's needs, even after E3's admission of physical abuse. Added to this, R3 and E4 also witnessed E3 passing trays to residents after the physical abuse, which was only interrupted when the police came to the facility according to E4.

Findings include :

1) R3 has diagnoses of C1 - C4 Spinal Cord Injury and Quadriplegia. R3 was admitted to the facility on 1/29/10 and was observed on 6/23/10 as alert and oriented x3 and verbally responsive to stimuli .

Review of R3's incident report indicated that on 5/16/10 at 5:00 PM, R3 alleged to E4 (3-11 nurse) that E3 slapped her. This report also indicated that this physical abuse was witnessed by R2 and his sister.

According to R2, during 6/30/10 interview at 10:40 AM, E3 tightened R3's gait belt prior to transferring her on 5/16/10. When R3 complained about it, E3 slapped R3. R2 continued to say that R3 moved her wheelchair towards E3 in retaliation, pushing E3's back on the mechanical lifter behind E3. R2 added that when this happened, E3 choked R3, tilting R3's wheelchair and almost tipping it over. R2 said that after this, E3 left the room while R3 was crying.

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F9999	Continued From page 11 During interview on 6/23/10 at 11:00 AM, R3 verified R2's above statement that indeed, she was slapped and choked by E3 (3-11 Certified Nurse assistant / CNA) in the presence of R2 and his sister. During 6/30/10 phone interview at 9:10 AM, E4 said that on 5/16/10 she was in a room taking care of another resident, when R3 told her to immediately come to R3's room. E4 said that when she asked E3 (who was sitting at the 1st floor nurses station when E4 passed the 1st floor nurses station) what happened, E3 responded "I don't know." E4 continued that when she got to R3's room, R3 said that E3 slapped and choked her, to which R2's sister responded that R3 is telling the truth. E4 then said that she went to E3 who admitted at this time that she "smacked" R3 after R3 pushed her wheelchair towards her (E3) while E3 was tightening R3's belt, in preparation for R3's transfer. E4 then said that she went back to finish assisting the other resident she was working with before because the resident there might fall, leaving E3 at the 1st floor nurses station by herself, in an area where E3 could have contact with residents. E4 added that 5 - 7 minutes later, E3 told her that E3 already called E2 (Director of Nursing). E4 said, E2 called back after a few minutes. E4 said that after she told E2 of the incident between R3 and E3, E2 instructed E4 to chart the incident and make an incident report. When asked if E2 told her to make sure that E3 does not have anymore contact with any of the residents, E4 responded no but that she knew that E3 should not be allowed to have any contact with any resident after what happened. E4 then went back to the resident she was working with prior to the incident, leaving E3 again at the first floor nurses station	F9999		

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F9999	Continued From page 12 unsupervised, because she was afraid the resident might fall, . According to E3, during 7/1/10 interview at 11:49 AM, after the incident with R3 she stayed at the 1st floor nurses station the entire time until the police came to the facility. When informed that E4 said that she (E4) went to a resident room to take care of a resident, E3 said that indeed E4 went to take care of a resident and left her by herself at the nurses station and came back later. The 1st floor nurses station is in front of the elevator that services the 2nd and 3rd floor, and is in the middle of the 1st floor unit. During above interview, E4 also said that she saw E3 pass dinner trays to 4 residents prior to the police coming to the building, but that she did not complete the tray pass as police took her away. E4 said E3 looked upset and looked like she was about to cry while passing trays, that she (E4) even told E3 that if she does not feel good while passing the trays, E3 can stay at the nurses station. When asked why she let E3 pass dinner trays to 4 residents, E4 said that because when she was about to tell R3 after R3 passed the 4 trays not to pass them, the police came in and took E3 away. E4 failed to follow the facility's abuse prevention policy by not removing E3 immediately from resident contact. Prior to speaking to E2 over the phone, E4 already received the allegation of abuse from R3 while in R3's room. In addition, R2's sister confirmed to E4 that the physical abuse allegation of R3 was true. E3 admitted the abuse to E4 when E4 asked her about it after exiting R3's room. During this time, E4 said that E3 knew that the police were at the front door, so	F9999		

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F9999	Continued From page 13 E3 met with them first to explain what happened earlier between her (E3) and R3. During the 7/1/10 interview, E3 denied passing trays after physically abusing R3. R3 during 6/23/10 interview at 11:00 AM, said that she called the police because after E3 slapped and choked her and even she reported it to E4, R3 still saw E3 passing trays to residents. During above interview with E4 on 6/30/10, E4 also said E3 passed 4 trays to residents but did not complete it as the police came to the facility. Review of facility's Abuse Prevention Program indicated that, "Employees of the facility who have been accused of mistreatment will be removed from resident contact immediately until the results of the investigation have been reviewed by the administrator or the designee." 2) In another incident, R3 alleged on 6/23/10 at 11:00 AM, that E6 (11-7 CNA) tried to kiss her early in the morning while she was watching TV in her room in February 2010. R3 said E6 was touching her hair and forehead initially then tried to kiss her twice, to which she said No and put her hand up to prevent E6 from kissing her. R3 said she was afraid because she was helpless and told E7 (therapist) that morning. During 6/23/10 interview at 1:25 PM, E7 confirmed that R3 told him that E6 tried to kiss her during the 11-7 shift. E7 said that he immediately told E1 (administrator). Although, E6 was terminated on 2/22/10 according to his personnel file for "inappropriate" behavior, this allegation and investigation was not sent to IDPH at all. Review of the abuse	F9999		