STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145316	A. BUILDING _____ B. WING _____	C 12/10/2004

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

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F9999	FINAL OBSERVATIONS State Licensure Findings: 300.1210a) The facility must provide the necessary care and services to attain or maintain the highest	F9999		

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F9999	Continued From page 8 practicable physical, mental, and psychosocial 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. 300.1210b)6) All necessary precautions shall be taken to assure that the resident's 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. These Regulations are not met as evidenced by: Based on Observation, Record Review, and Interview the facility failed to supervise a resident by not: a. Closely monitoring R1's whereabouts on 10/31/04 when documentation showed R1 had short and long term memory problems, decreased safety awareness, and an unsteady gait. b. Assessing R1 for risk of elopement c. Developing a plan to prevent R1 from eloping from the facility. R1 was found approximately ten minutes later by the local police department approximately one block from the facility. This applies to one resident (R1) out of 29 residents who were at risk for eloping from the facility.	F9999		

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F9999	Continued From page 9 The findings include: 1. A review of the Admission Information Sheet documents R1 is a 53 year old resident with diagnoses including, Brain Tumor, Status Post Craniotomy and Tumor Resection, Sinus Headaches, Weakness, Transient Ischemic Attacks, Anxiety, Dementia, Paranoid, and Gout. Additionally, a Psychiatry Note of 10/25/04 documented a diagnosis of Organic Brain Syndrome. The Minimum Data Set (MDS) of 10/ 21/04 assessed R1 as having long and short term memory problems. R1 is moderately cognitively impaired, R1 has poor decision making skills for activities of daily living and supervision is required. The MDS also assessed R1 as wandering with no rational purpose, seemingly oblivious to needs or safety. The Falls Resident Assessment Protocol dated 10/21/04 included a summary that stated the resident is at risk for falls due to cognitive function (deficits) and diagnosis of weakness. R1 is documented as needing reminders to ask for assistance with transfers and ambulation. 2. A review of R1's Nursing Notes documents the following: a. 10/17/04- confused to time and place... assisted with ambulation-very unsteady on feet. b. 10/18/04 - assisted to bathroom, gait unsteady. c. 10/20/04 - gait "wobbly". Resident heading out in hallway to "go to the bathroom". Redirected. Resident's thought processes slow, responds to redirection slowly. d. 10/27/04 - Resident found missing from his room. He was located in another room in the closet, with another resident's clothes on....	F9999		

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F9999	Continued From page 10	F9999		

e. 10/31/04 (02:50am) - Awake/anxious. Telling RN "don't touch any switches." ... resident stated, "because, can't you see the smoke and the colors?".... Resident reluctant to take comfort in anything..... Ativan 0.5 milligrams given orally for anxiety.
f. 10/31/04 (4:20pm) Resident up ambulating after removing alarm from his shirt. Resident asking people to, "call my daughter¿.
g. 10/31/04 (4:25pm) Nurse approached by another resident who was concerned that R1 is walking around looking for his daughter. Began in-house search...resident has been having hallucinations recently and has been found in other resident's rooms.
h. 10/31/04 (04:30) Received call from local police department that resident was picked up about a block from the entrance of the facility... returned to the facility without injury.

3. A Social Service Note dated 10/21/04 states that R1 was wandering through the halls in his wheelchair. He appears to be disoriented. The note continued, 'When his daughter answered, I spoke with her about elopement risk with his confusion... refused to have R1 placed on Alzheimer's Unit'.

4. A review of R1's Comprehensive Care Plan showed no plan for elopement risk prior to 11/01/04.

5. During an observation of the area near the facility, a large river is located about 2 blocks from the front door. No barriers were noted between the river and the facility. A highway, with a speed of 30 miles per hour through town, was observed 0.4 miles east of the facility.

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6. Review of the weather conditions on 10/31/04 at 04:00 pm, for the general area of the facility, showed the temperature to have been 58 degrees Fahrenheit. The winds were out of the west at nine miles per hour with scattered clouds, per the National Weather Bureau.

7. On 11/15/04, the topic of R1's elopement was discussed with the staff. E1, the administrator, stated it was not felt that R1 had been an elopement risk. He did wander throughout the facility, but never attempted to exit the building. Therefore, he was not considered an elopement risk.

During a interview with E2 (assistant administrator) on 11/15/04 at 11:18am, E2 stated that R1 was alert and disoriented. He used a wheelchair alarm while in the chair for fall prevention.... our facility had made an earlier offer to the family to place the resident in the Alzheimer's unit. The Family declined.

During a interview with E3 (Director of Nursing) on 11/15/04, E3 stated that the resident was confused: he may not remember where his bathroom or room was.... (concerning the Elopement). "The only thing we can figure out (is) the front door. My GUESS is he walked out the door with visitors."

On 11/15/04 at or about 2:00pm E4, the Social Services Director was interviewed regarding R1's elopement. E4 stated that R1's wandering was aimless. The resident never showed any desire to leave the facility. R1 appeared to be confused and had to be re-oriented to his room. I spoke to

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his daughter on 10/21/04. I brought up the elopement risk factor when she indicated that in the past he had attempted to climb out a window at home. E4 stated," I asked her if R1 should be placed on the Alzheimer's Unit. She did not feel R 1 was an elopement risk, and it the placement was not necessary. I did not do an elopement risk assessment at that time. In the future I will assess all residents for elopement risk who exhibit wandering behavior or have a diagnosis that includes any evidence of brain dysfunction."

On 11/15/04 at or about 11:55am, E5 (LPN/rehab nurse) was interviewed concerning the status of R1. E5 noted that R1's gait was unsteady. His equilibrium was off, and he weaved when he ambulated. He was unable to ambulate safely. On 10/31/0 at about 04:00pm, E5 observed R1 sitting in a wheelchair with a wheelchair alarm in place. "Around 04:20pm, R2 an alert and reliable resident, approached me. R2 asked me if R1 was supposed to be walking by himself. R2 saw R1 in the receptionist's office trying to call his daughter. R2 was concerned about R1. R2 did not see which direction R1 went. A certified nursing assistant and I began a search in the immediate area. R1's wheelchair was found in the West
wing shower room. I then informed E3. About 04 :30pm the local police department called and informed me that they had found a resident about a block from the facility. Upon return to the facility, R1 was found to be without injury. I then talked to the receptionist about the elopement. She stated that R1 was not on the Elopement Risk List. I (E5) verified this. Monitoring R1's whereabouts every 15 minutes was initiated."

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On 12/03/04 at or about 10:00am, R2 was interviewed regarding R1's status and elopement. She stated,
"On 10/31/04, I heard R1's alarm go off. He was near the nurses' station on the west wing. The nurse turned off the alarm, and he started walking with his wheelchair. I started for the front office. He got their first, because I had made a stop along the way. He tried to use the phone in the receptionist's office. R1 then asked me if I had a cell phone. I told him that I did not. I turned around, and R1 was gone. I was concerned because his family had mentioned to me that he needed to be in a wheelchair because he had a history of falls. I then told the nurse that I could not find him. The staff began looking room to room for him¿.

8. A Nursing Note dated 10/31/04-4:30pm documented that Staff was inserviced on resident alarms and 15 minute checks.

9. On 12/03/04 at or about 10:34am, E6 (LPN) was interviewed regarding R1's physical and mental status. E6 noted that he (R1) was confused/forgetful. He had to be cued to go to the dining room or activities. He would be attempting to return to his room and wander to the end of the hall, even though he had just been in it. He used a wheelchair alarm for safety. His gait was very unsteady and he never did safe transfers. He never locked the wheels while transferring from or to the chair.

10. During a phone conversation with Z1 (physician) on 12/08/04, Z1 stated that R1, because of his Dementia and physical condition, needs to be in a supervised living area. He should not be unsupervised in the community.