PRINTED: 05/03/2007 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		145316	B. WIN				C 1/2006
	ROVIDER OR SUPPLIER	NTER	I	5	REET ADDRESS, CITY, STATE, ZIP CODE 555 WEST KAHLER WILMINGTON, IL 60481		.,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	TS	F	000			
	Investigation of Co	omplaint #0674348/IL25440 #0674364/IL25456					
	F324 applies to bot	th complaints.					
F 324 SS=K		Survey was conducted. DENTS	F:	324			11/20/06
30-K		nsure that each resident supervision and assistance accidents.					
	by: Based on Record F Observation, the faresidents surveyed were identified and a "High Risk" for farestained a sublux the C4-C5 level with non-responsive on care unit of the host of the right hip requestrained a fracture surgical intervention bruises and abrasic sustained bruises, requiring emergency failures to supervising immediate jeopardy Findings include: The record of R1, and a surveyed and a surveyed a surveyed a surveyed and a surveyed a surve	Review, Interview and cility failed to supervise 5 of 5 (R1, R2,R3, R4, R5) that for met the criteria of being at Ills. This failure resulted in; R1 ation of the cervical spine at the spinal cord injury and was a ventilator in the intensive spital, R2 sustained a fracture siring surgical intervention, R3 to of the right hip requiring n, R4 sustained numerous ons from repeated falls, R5 thematomas and a laceration by room treatment. These the residents resulted in an any that began on 9/30/06.			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIED/CLIA

-	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION G	COMPLE	TED
		145316	B. WIN	1G _			C 1 /2006
	PROVIDER OR SUPPLIER	NTER		5	REET ADDRESS, CITY, STATE, ZIP CODE 55 WEST KAHLER VILMINGTON, IL 60481	1170	172000
(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)	ULD BE	(X5) COMPLETION DATE
F 324	diagnoses of Parkin Recurrent Urinary Disorder and Altere on 10-20-06. R1's record contain dated 9/20/06 with the "Fall Risk Asse above represents "R1's record contain which states, "Resi normal risk for falls plan dated 9/21/06 wheelchair and proexercise." R1's record contain documentation; on found on floorlarge of head. Laceration 1 cm wide noted to noted pack applied toemergency roc "Certified Nurse As fell back andred armtransferred to (ER).",on 10/7/06 a bathroom. Has 2 h with abrasions. Ale wheelchair with boo 10/10/06 at 3:15 Pt chair onto the floor, bed.", on 10/16/06 lying on mattress wher with lap buddy 10/17/06 at 12:15A room on right side I hematoma noted to to right side of kneeds.	nson's Disease, Ulcers, Fract Infection, Schizoaffective and Mental Status was reviewed as a "Fall Risk Assessment" a score of 16. According to assessment" a total score of 10 or	F3	324			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145316	B. WIN		·		C 1/2006
	PROVIDER OR SUPPLIER	NTER	•	55	EET ADDRESS, CITY, STATE, ZIP CODE 5 WEST KAHLER ILMINGTON, IL 60481		
(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)	ULD BE	(X5) COMPLETION DATE
F 324	Continued From pa	ige 2	F3	24			
	lacks interventions in use prior to the fato prevent further fareport for R1 dated slipped out of wheer report lacks intervent falls and infurther falls. An incidated 10/6/06 state back of head and bedocumentation of the prevent falls before changes in intervent fall." An incident/act 10/10/06 states, "R Fell forward out of report lacked documentation of the prevent falls interventions plann future. An incident, 10/16/06 stated that mattress(low bed) with the wheelchair on the documentation of the prevent further falls for R1 dated 10/17/TABS alarm sound responded. Reside Hematoma to left sendened area and the followarrival at skilled numbed in fetal position increasingly letharges.	nt report dated 9/30/06 for R1 for preventing falls that were all and interventions planned alls. An incident/accident 10/4/06 states, "resident elchairin front hallway." This intions currently in use to terventions planned to prevent ident/accident report for R1 es, "patient fell back and hit eack", the report lacks he interventions used to the fall occurred and what entions were made after the ecident report for R1 dated esident sitting in wheelchair. wheelchair onto floor." This mentation of interventions in prior to the this fall and ed to prevent falls in the faccident report for R1 dated at R1, "fell forward onto with the lap buddy in place and op of her." This report lacked he interventions planned to an incident accident report for R1 dated to an incident accident report for R1 dated to prevent falls in the faccident report for R1 dated to prevent					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SU COMPLE		
		145316	B. WI	1G			C 1/2006
	PROVIDER OR SUPPLIER BY HEALTH CARE CE	NTER	•	5	EET ADDRESS, CITY, STATE, ZIP CODE 55 WEST KAHLER VILMINGTON, IL 60481		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 324	10/17/06, contains "severe dehydration most likely secondary subluxation of the Oscan), patient is un in the right knee ca as well." Emergendocumentation that (fecal) that has been obtain a rectal temproted." The hospit physician progress failure secondary to dehydration" On 10/20/06 R1 was care unit of the host ventilator dependar multiple bruising to extremities. R1 has side of the head and was not responsive that time. R1 was a urinary drainage bas nasogastric tube draws receiving intravious receiving re	documentation that R1 has n with hyponatremia, seizures ary to hyponatremia, 24- C5 vertebrae(per CT responsivebruising is noted If region and lower extremity by room notes for R1 contains not digitally removed per RN to be returneseizure activity all record contained a note that states, "Respiratory or multiple problems, Its observed in the intensive pital. R1 was intubated and the face, neck and lower dalarge hematoma to the left of the back of the neck. R1 to verbal or tactile stimuli at not moving her extremities. A signoted as well as a an ing bile colored fluid. R1 venous fluids and antibiotics. O/20/06 at 10:00 AM with E2, nistrator, she stated that, "I did falls of R1 until the resident ergency room on 10/17/06. Since Nurse (LPN) E2, who was ne she started neuro checks need cognitively after the fall. Led the physician after R1 fell back." In an interview with E1, in 10/20/06 at 9:45 AM, she LPN was "suspended pending ne investigation of R1's fall	F	324			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SURPLIER/CLIA

-	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION NG	(X3) DATE SU COMPLE	TED
		145316	B. WII	NG _			C 1 /2006
	PROVIDER OR SUPPLIER	NTER		5	REET ADDRESS, CITY, STATE, ZIP CODE 555 WEST KAHLER WILMINGTON, IL 60481	1170	172000
(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 APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 324	she seemed fine." Certified Nurse Ass the morning after the uncooperative as uncooperative	e morning after the fall and In an interview with E4, a sistant (CNA), she stated on he fall R1 was, "fine, she was sual but she ate her stated R1 had, "bruises on k and had a black eye." E4 bring all her extremities and a Z1, a nurse case manager at R1 is being cared for, she received R1 unresponsive, ernal pacemaker, was ed on a ventilator for and had seizures. Z1 stated natoma on the left side of her at the base of the back of her o her lower extremities. E5, the owner, he stated E7, I for R1, was terminated. E5, the owner, he stated E7, I for R1, was terminated. E6, the owner, he stated E7, I for R1, was terminated. E7, I for R1, was terminated. E8, the owner, he stated E7, I for R1, was terminated. E8, the owner, he stated E7, I for R1, was terminated. E8, the owner, he stated E7, I for R1, was terminated. E8, the owner, he stated E7, I for R1, was terminated. E8, the owner, he stated E7, I for R1, was terminated. E8, the owner, he stated E7, I for R1, was terminated. E8, the owner, he stated E7, I for R1, was terminated. E8, the owner, he stated E7, I for R1, was terminated. E9, the owner, he stated E7, I for R1, was terminated. E9, the owner, he stated E7, I for R1, was terminated. E9, the owner, he stated E7, I for R1, was terminated. E9, the owner, he stated E7, I for R1, was terminated. E9, the owner, he stated E7, I for R1, was terminated. E9, the owner, he stated E7, I for R1, was terminated. E9, the owner, he stated E7, I for R1, was terminated.	F	324			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		CONSTRUCTION	(X3) DATE SU COMPLE	
		145316	B. WING	3			C 1/2006
	PROVIDER OR SUPPLIER	NTER		555 W	ADDRESS, CITY, STATE, ZIP CODE EST KAHLER INGTON, IL 60481	1	.,,2000
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUNDS OF THE APPROVINCE OF	ULD BE	(X5) COMPLETION DATE
F 324	dated 10/22/06 state back into bed and faccident report lack prevent falls in use lacked planned into the future. The record of R3, at to the facility with d Chronic Obstructive Hypothyroidism, Dereviewed on 10/20/contained a "Fall R R3 at 11 which reprecord contains nuture 10/11/06 at 1:15 All on floor in middle of sideResident was R3's record contained at 10/12/06 that of 10/11" R3's redocumentation date "Xray to right hip went to the emerge consultation report accidental fall and fracture" R3 had siffracture. R3's record R3 fell previously a left wrist. R3's record fall care plan, investinguries and interventure. The record of R4, at the facility with diagodisorder, Hypothyropisease was reviewed.	ge 5 sed that R2, "tried to get ell on the floor." R2's incident/ ked the interventions to at the time of the fall and erventions to prevent falls in an 83 year old female admitted iagnoses of Fracture Left Hip, e Pulmonary Disease, ementia and Lymphoma, was and and 10/30/06. R3's record isk Assessment" that scored resents "High Risk" R3's rsing documentation dated and that states, "Resident found and front hallway on her right and able to move all extremities." and nursing documentation at states, "No ill effects from fall cord contains nursing and 10/13/06, at 4:30 PM andone" R3 subsequently and the hospital states, "an are sultant right femoral neck argical intervention for the hip ard contained documentation and sustained a fracture of the and lacked documentation of a artigation of R3's falls with antions to prevent falls in the and 62 year old male admitted to gnoses of Dementia, Seizure bidism, and Parkinson's and on 10/30/06. R4's record and ocumentation of 13 incidents of	F 3:	24			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		145316	B. WII	NG _			C 1/2006
	PROVIDER OR SUPPLIER	NTER	•	5	REET ADDRESS, CITY, STATE, ZIP CODE 55 WEST KAHLER VILMINGTON, IL 60481		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 324	falls between 8/06 varying degrees of abrasions. All excereports for R4 for the September and Octowhat interventions prevent R4 from fall were planned to profuture. The record of R5, at to the facility with defended Mental Retardation R5's record contains between 9/7/06 and contains document helmet due to seize record lacks a "Fall record lacked document to prevent future. Facility policy titled Resident Falls" requested policy to act in a preassess those reside preventive strategic environment as posassessed and the rewill be evaluated for resident fall shall be clinical record." The policy regarding fall E5 and E1 were not of an Immediate Jeon 10/30/06, the facility to the Immediate Jeon 10/30/06, the facility policy regarding fall the Immediate Jeon 10/30/06, the facility policy regarding fall the Immediate Jeon 10/30/06, the facility policy regarding fall the Immediate Jeon 10/30/06, the facility policy regarding fall the Immediate Jeon 10/30/06, the facility policy regarding fall the Immediate Jeon 10/30/06, the facility policy regarding fall the Immediate Jeon 10/30/06, the facility policy regarding fall the Immediate Jeon 10/30/06, the facility policy regarding fall the Immediate Jeon 10/30/06, the facility policy regarding fall the Immediate Jeon 10/30/06, the facility policy regarding fall the Immediate Jeon 10/30/06, the facility policy regarding fall the Immediate Jeon 10/30/06, the facility policy regarding fall the Immediate Jeon 10/30/06 the facility policy regarding fall the Immediate Jeon 10/30/06 the facility policy regarding fall the Immediate Jeon 10/30/06 the facility policy regarding fall the Immediate Jeon 10/30/06 the facility policy regarding fall the Immediate Jeon 10/30/06 the facility policy regarding fall the Immediate Jeon 10/30/06 the facility policy regarding fall the Immediate Jeon 10/30/06 the facility policy regarding fall the Immediate Jeon 10/30/06 the facility policy regarding fall the Immediate Jeon 10/30/06 the facility policy regarding fall the Immediate Jeon 10/30/06 t	and 10/22/06. R4 sustained injury ranging from bruises to ept one of the incident/accident he months of August, tober lacked documentation of were currently utilized to ling and what interventions event him from falling in the a 26 year old female admitted iagnoses of Seizures and was reviewed on 10/30/06. R5's record ation that R5 wears a padded ares and falls, however the Risk Assessment." R5's mentation of a comprehensive are injuries due to seizures and facility Policy Regarding uires that, "it is this facility's coactive manner to identify and ents at risk for falls, plan for es and facilitate as safe an asible. All resident falls will be esident's existing plan of care of the documented in the resident's he facility failed to follow their list as evidenced above. Detified on 10/30/06 at 8:45 AM opardy related to falls. While coardy was removed on y remains out of compliance at a Additional time is needed to	F	324			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		145316	B. WIN				C 1/2006
	ROVIDER OR SUPPLIER Y HEALTH CARE CE	NTER		5	EET ADDRESS, CITY, STATE, ZIP CODE 55 WEST KAHLER VILMINGTON, IL 60481		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 324	revised policies and implementation. Surveyor confirmed following actions to jeopardy: 1. All residents are a new fall risk asse 2. All resident's as will have care plan 3. All staff will be in high-risk residents. falls, nutrition, offer constipation, CNA to fresident needs. 4. A QA evaluation determine what shi falls and what staff training. 5. Additional in-serincident/accident reinterventions are in assessments and confirmed for a completion. All care Plans were sidents to ensure 8. QA sheets (fall tall interventions are	te the effectiveness of the d procedures to ensure their d procedures to ensure their d procedures to ensure their d that the facility took the remove the immediate e being evaluated for falls and ssment is being done. Sessments as a high fall risk added. In serviced on how to monitor Content including: monitoring ing of fluids, UTI's, tracking forms and anticipation of the last 3 months to fit has the most problems with need additional in-service evice education on completing eports to include what use, in what order, complete evictome of event. It reviewed for fall assessments on ill be reviewed for all high-risk ecompletion. It is completion. It is addressed on a disciplinary team.	F	324			
F9999		be reviewed and updated as	F99	999			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	X2) MULTIPLE CONSTRUCTION . BUILDING		(X3) DATE SURVEY COMPLETED	
		145316	B. WIN				C 1/2006
	PROVIDER OR SUPPLIER BY HEALTH CARE CE	NTER		55	EET ADDRESS, CITY, STATE, ZIP CODE 55 WEST KAHLER ILMINGTON, IL 60481		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	a) The facility shall procedures, govern the facility which she Resident Care Police least the administration the medical advisor representatives of such and all thereunder. These followed in operation reviewed at least are evidenced by writte of such a meeting. Section 300.1210 Consuming and Personal The facility must and services to attapracticable physical well-being of the representative and personal care and personal care need measures shall including procedure by General nursing minimum the follow a 24-hour, seven displayed.	esident Care Policies have written policies and ling all services provided by hall be formulated by a cy Committee consisting of at ator, the advisory physician or ry committee and hursing and other services in holicies shall be in compliance rules promulgated written policies shall be ag the facility and shall be hunually by this committee, as an, signed and dated minutes Seneral Requirements for hal Care provide the necessary care hain or maintain the highest I, mental, and psychological sident, in accordance with hyprehensive assessment and hate and properly supervised hersonal care shall be provided meet the total nursing and has of the resident. Restorative hude at a minimum the hes: hall include at a hing and shall be practiced on	F99	99			

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			(X3) DATE SU COMPLE	TED
	145316	B. WI	NG _			C 1/2006
ROVIDER OR SUPPLIER	NTER		5	55 WEST KAHLER	1170	172000
(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOU	JLD BE	(X5) COMPLETION DATE
assure that the resi as free of accident nursing personnel s that each resident is and assistance to p These requirement by: Based on Record F Observation, the fa residents surveyed were identified and a "High Risk" for fa sustained a sublux the C4-C5 level wit non-responsive on care unit of the hos of the right hip requ sustained a fracture surgical interventio bruises and abrasic R5 sustained bruise laceration requiring Findings include: 1. The record of R diagnoses of Parkin Recurrent Urinary Disorder and Altere on 10-20-06. R1's Assessment" dated According to the "F score of 10 or above R1's record contain	idents' environment remains hazards as possible. All shall evaluate residents to see receives adequate supervision prevent accidents. Is were not met as evidenced Review, Interview and cility failed to supervise 5 of 5 (R1, R2, R3, R4, R5) that for met the criteria of being at lls. This failure resulted in: R1 ation of the cervical spine at h spinal cord injury and was a ventilator in the intensive spital, R2 sustained a fracture siring surgical intervention, R3 as of the right hip requiring n, R4 sustained numerous ons from repeated falls, and see, hematomas and a pemergency room treatment. 1, a 67 year old female with mean's Disease, Ulcers, Fract Infection, Schizoaffective and Mental Status was reviewed record contains a "Fall Risk in 19/20/06 with a score of 16. Tall Risk Assessment" a total re represents "High Risk."	F9:	999			
	ROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa assure that the resi as free of accident nursing personnel s that each resident i and assistance to p These requirement by: Based on Record F Observation, the fa residents surveyed were identified and a "High Risk" for fa sustained a sublux the C4-C5 level wit non-responsive on care unit of the hos of the right hip requ sustained a fracture surgical interventio bruises and abrasic R5 sustained bruise laceration requiring Findings include: 1. The record of R diagnoses of Parkin Recurrent Urinary Disorder and Altere on 10-20-06. R1's Assessment" date According to the "F score of 10 or abov R1's record contain which states, "Resi	THE CORRECTION A 145316 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 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. These requirements were not met as evidenced by: 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.	ROVIDER OR SUPPLIER Y HEALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 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. These requirements were not met as evidenced by: 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. 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R1's record contains a care plan dated 9/12/06 which states, "Resident has a greater than	THE CORRECTION IDENTIFICATION NUMBER: A BUILDIN B. WING _ SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 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. These requirements were not met as evidenced by: 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. 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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. Findings include: 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." R1's record contains a care plan dated 9/12/06 which states, "Resident has a greater than	THE CORRECTION A BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE STORE TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY STATE, ZIP CODE STORE THAN TO THE CONTINUATION OF THE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY STATE, ZIP CODE STORE THAN TO THE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY OF THE APPROPRIATE DISCUSS OF THE APPROPRIATE DISCUSS. THE APPROPRIATE DISCUSS OF

-	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION IG	COMPLE	TED
		145316	B. WIN	1G _			C 1 /2006
	PROVIDER OR SUPPLIER	NTER		5	REET ADDRESS, CITY, STATE, ZIP CODE 555 WEST KAHLER VILMINGTON, IL 60481	, 1110	172000
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	wheelchair and pro exercise." R1's record contain documentation rela 9/30/06 at 7:00 PM floorlarge hemato Laceration 3 centimented to forehead wappliedOrders recomergency room. 10/6/06 at 7:00 AM (CNA) stated reside on right back and right back at 15 PM chair onto the floor, bed." 10/16/06 at 4:10 PM mattress with wheelap buddy and body 10/17/06 at 12:15A room on right side is hematoma noted to right side of kneeresident transporter. An incident/accider lacks interventions in use prior to the fato prevent further fareport for R1 dated slipped out of wheeless.	include "lap buddy when in a vide ambulation and state of alls: , "Resident found on ama noted to left side of head. The interest of the inter	F99	999			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION NG	(X3) DATE SU COMPLE	TED
		145316	B. WI	NG _			C 1/2006
	PROVIDER OR SUPPLIER	NTER		5	REET ADDRESS, CITY, STATE, ZIP CODE 555 WEST KAHLER WILMINGTON, IL 60481	1170	172000
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	prevent falls, and ir prevent further falls for R1 dated 10/6/0 hit back of head an documentation of the prevent falls before changes in interver fall." An incident/act 10/10/06 states, "R Fell forward out of report lacks documented to prevent falls interventions plann future. An incident/attored for the wheelchair on the wheelchair o	An incident/accident report 6 states, "patient fell back and d back." The report lacks he interventions used to the fall occurred, and what hitions were made after the cident report for R1 dated esident sitting in wheelchair. Wheelchair onto floor." This hentation of interventions in prior to the this fall, and hed to prevent falls in the haccident report for R1 dated t R1, "fell forward onto hith the lap buddy in place and hop of her." This report lacks he interventions planned to he interventions planned to ha incident accident report had states that, "Resident hing. Nurse immediately her found on floor on right side. hide of forehead. Large habrasion to right knee" Adical system's "Run Sheet" hing documentation, "Upon hering facility patient found in	F99	999			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		145316		1G		C 11/01/2006	
NAME OF PROVIDER OR SUPPLIER EMBASSY HEALTH CARE CENTER			•	5	EET ADDRESS, CITY, STATE, ZIP CODE 55 WEST KAHLER VILMINGTON, IL 60481		
(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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F9999	obtain a rectal tempoted." The hospit physician progress failure secondary to dehydration" On 10/20/06 R1 was care unit of the host ventilator dependar multiple bruising to extremities. R1 has side of the head and was not responsive that time. R1 was not urinary drainage bas nasogastric tube draws receiving intravious receiving re	an digitally removed per RN to be peratureseizure activity al record contained a note that states, "Respiratory of multiple problems, as observed in the intensive pital. R1 was intubated and the face, neck and lower a la large hematoma to the left of the back of the neck. R1 to verbal or tactile stimuli at not moving her extremities. A large was noted as well as a laining bile colored fluid. R1 venous fluids and antibiotics. 0/20/06 at 10:00 AM with E2, histrator, she stated that, "I did falls of R1 until the resident ergency room on 10/17/06. Itical Nurse (LPN), E2, who had me she started neuro a unchanged cognitively after she paged the physician after of call back." In an interview istrator, on 10/20/06 at 9:45	F99	999			
	"bruises on the bac	k of her neck and had a black was, "moving all her					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SURPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145316	B. WIN	IG _		C 11/01/2006	
NAME OF PROVIDER OR SUPPLIER EMBASSY HEALTH CARE CENTER				5	REET ADDRESS, CITY, STATE, ZIP CODE 55 WEST KAHLER VILMINGTON, IL 60481	1170	172000
(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 SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	the hospital where stated the hospital had to have an exterintubated and place respiratory distress R1 had a large here head, a hematoma neck and bruising to the large here head, a hematoma neck and bruising to the large here head, a hematoma neck and bruising to the large here head, a hematoma neck and bruising to the large here head, a hematoma neck and bruising to the large here head, a hematoma neck and its large here head, a hematoma neck and its large here head. 2. The record of R2 was admitted to the Hypertension, GER post fracture of left dates 10/20/06 and contained a Fall Ris which stated R2 was However, R2 had a record contained no large here here here here here here here h	Z1, a nurse case manager at R1 is receiving care, she received R1 unresponsive, ernal pacemaker, was ed on a ventilator for and had seizures. Z1 stated natoma on the left side of her at the base of the back of her o her lower extremities. E5, the facility's owner, he who cared for R1, was 2, an 85 year old female who a facility with diagnoses of D, Dementia, Depression and hip, was reviewed on survey 10/30/06. The record of R2 sk Assessment dated 4/24/06 as not at risk for falls. history of a hip fracture. R2's cursing documentation dated do repainAmbulance here." ed a discharge plan from the	F99)99			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		145316	B. WIN	1G _		C 11/01/2006	
NAME OF PROVIDER OR SUPPLIER EMBASSY HEALTH CARE CENTER			•	5	REET ADDRESS, CITY, STATE, ZIP CODE 155 WEST KAHLER VILMINGTON, IL 60481		
(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 CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH CORRECT PROPERTY OF THE APPROVIDE PROVIDER OF THE APPROVIDE PROVIDE PROVI		OULD BE	(X5) COMPLETION DATE	
F9999	admitted to the facil Left Hip, Chronic O Disease, Hypothyro Lymphoma, was re 10/30/06. R3's record Assessment" that is represents "High R nursing documenta AM that states, "Recoff front hallway on able to move all excontained nursing of that states, "No ill er R3's record contained ated 10/13/06, at 4 done" R3 subsetemergency room of report from the host and resultant right in had surgical interversecord contained dopreviously and sust wrist. R3's record lacare plan, investigated and interventions to the facility with disciplination of the surgical from bruises to abrain cident/accident reading the surgical from	Ity with diagnoses of Fracture bstructive Pulmonary oldism, Dementia and viewed on 10/20/06 and ord contained a "Fall Risk cored R3 at 11 which isk." R3's record contains tion dated 10/11/06 at 1:15 sident found on floor in middle ther right sideResident was tremities." R3's record documentation dated 10/12/06 ffects from fall of 10/11" Is nursing documentation :30 PM "Xray to right hip quently went to the fithe hospital. A consultation pital states, "an accidental fall femoral neck fracture." R3 ention for the hip fracture. R3's pocumentation R3 fell ained a fracture of the left acked documentation of a fall tion of R3's falls with injuries, or prevent falls in the future.	F99	66			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		145316		NG _		C 11/01/2006	
NAME OF PROVIDER OR SUPPLIER EMBASSY HEALTH CARE CENTER				5	REET ADDRESS, CITY, STATE, ZIP CODE 55 WEST KAHLER VILMINGTON, IL 60481	,	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	from falling in the function of Relative to the facing and Mental Retards 10/30/06. R5's record falls between 9/7/contains document helmet due to seizu record lacks a "Fall record lacked document of lacked document to prevent future falls. 6. Facility policy titt Resident Falls" requested policy to act in a proposition of the preventive strategies environment as possessed and the resident fall shall be clinical record."	were planned to prevent him	F99	999			