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 _____	03/22/2007

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

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F 514	Continued From page 62 complete and readily accessible. This is for 2 residents inside the sample of 24 (R12 and R26) and 6 residents outside of the sample (R33, R34, R25, R36, R37, and R38). The findings include: During the survey on 3/19/07 the surveyors performed a medication/narcotic count with the nurses at the facility. Multiple doses of Vicodin (Class III medication) was found to be missing from December 2006 through March 19, 2007. The surveyors were reviewing the residents records for MAR's (Medication Administration Records) from December 2006 to March 2007 to check if the Vicodin pills had been signed out as administered to the residents for these months. Review of the residents records showed that the prior months MAR's were not located in the medical records. The last MAR's that were found in the residents medical record were the MAR's for December 2006. The MAR's for January, February, and the first 15 days of March were not filed in the residents medical record. The surveyors requested the MAR's for January, February, and the first 15 days of March. It took 2 days to receive all of the MAR's requested for R12, R26, R33, R34, R35, R36, R37, and R38. On 3/21/07 E3 (Director of Nurses) was interviewed and questioned why it took so long for the MAR's to be located and given to the surveyors. E3 stated, "The MAR's haven't been filed since December." No other explanation was given.	F 514		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS	F9999		

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F9999	Continued From page 63 300.1210a) 300.1620a) 300.3240a) Section 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 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. Section 300.1620 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not neglect a resident. (Section 2-107 of the Act) These Requirements were not met as evidenced by the following:	F9999		

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F9999	Continued From page 64 Based on record review, interview and observation the facility failed to: 1. Ensure that residents who are on medications that require monitoring for safe and therapeutic blood levels have those blood levels tested. This is for 4 residents inside the sample: R19, R1, R18, R24 and 2 residents outside the sample: R42 and R43. 2. Monitor signs and symptoms for overdose of an anticoagulant, R19. 3. Administer the appropriate dose of an anticoagulant, R19. 4. Clarify a physician's order for an anticoagulant, R19. As a result of these failures, R19 began to exhibit signs and symptoms of hypercoagulapathy on 3/18/07 in the early morning hours as documented in the nurses notes at 6:30am. R19 was sent to the hospital on 3/19/07 at 4:00pm with a diagnosis of hypercoagulopathy. The last lab report Prothrombin Time (PT) and International Normalized Ration (INR) for R19's anticoagulant level prior to the 3/19/07 admission to hospital was 1/26/07. Upon admission to the hospital, the lab summary report from the hospital showed R19's clotting time (INR) was found to be >10.0. The normal therapeutic range is 2.0 - 3.0. The PT level was > 165 (norms = 10.1 to 14.7). Findings include: 1) On 3/18/07 R19 was observed sitting in an adult recliner in the main dining room at 5:45pm. R19 was observed to have solid purple bruising on both anterior forearms and bloody urine in the foley tubing. R19 was alert and oriented, telling	F9999		

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F9999	Continued From page 65 surveyor her name and that she was awaiting dinner. R19 also stated that her eyeglasses had been stolen and that she is blind in one eye as it is and now she cannot even see with the other. On 3/19/07 at 9:40am R19 was again observed with bloody urine in the foley tubing. Review of R19's medical record found a current order on the physician order sheet (POS) for Coumadin 4mg three times a week on Mon., Wed., and Fri., and Coumadin 2mg four times a week on Wed., Thurs., Sat., Sun. in addition to 325mg of aspirin daily until INR reaches above 2.0. Review of R19's lab reports found that the last time R19 had blood clotting tests was on 1/26/07 at which timr they were within normal range. Surveyor asked E25 at 9:50am to locate a more recent clotting time blood test and E25 stated that the one from 1/26/07 is the most recent one. Nurses notes dated 3/18/07 document that R19 was observed at 6:30am with bruising on her arms. There was no follow-up found. Nurses notes on 3/19/07 at 9:50am document that R19 was observed to have bright red rectal bleeding. Also documented is that a physician saw R19 at 12:55pm on 3/19/07 and wrote an order for Ativan every six hours. A stat PT/INR with other blood work was ordered after facility notified physician of change in condition around 1:30pm. At 3:15pm R19 was exhibiting signs and symptoms of severe change in condition: low blood pressure, sunken eyes, weakness, pale, cool skin and dried blood around nose and mouth. The physician was called and facility left message. Doctor returned call and gave order to transport to hospital which was done at 4:00pm on 3/19/07. The physician's order for Coumadin on the	F9999		

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F9999	Continued From page 66 physician order sheet is not correct. It reads: Coumadin 4mg three times a week on Mon., Wed., and Fri., and Coumadin 2mg four times a week on Wed., Thurs., Sat., Sun. In addition, the review of medicine administration records for 1/15/07 thru 2/14/07 show coumadin administered on 4 days it should not have been. Per nurse in CCU at hospital, as of 3/22/07 R19 has received 4 units of packed red blood cells (RBC), 6 units of fresh frozen plasma (FFP) with more FFP to be infused today, 3/22/07. In addition, R19 is exhibiting decreased levels of alertness and is to undergo a CT scan of the head today, 3/22/07. 2) Review of medical records for R42 and R43 found that both were receiving Coumadin without orders for blood levels to monitor therapeutic ranges. 3) Review of R24's medical record showed that R24 was admitted to the facility on 11/13/06 with diagnoses including Major Depression, Suicidal Ideations, Anxiety Disorder, and Mood Disorder. Review of R24's psych progress notes also showed that R24 had a diagnosis of Bipolar Disorder. Review of R24's physician's orders showed that R24 takes Lithium Carbonate 900 mg every night and has been taking the Lithium since 11/14/06. Further review of R24's physician's orders showed no orders for lithium level to be monitored by the lab. Documentation in The Drug Information Handbook for Nursing 2007 regarding Lithium showed that "Lithium toxicity is closely related to serum levels," and to "Monitor serum concentrations and clinical response (efficacy and toxicity) to determine proper dose."	F9999		

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F9999	Continued From page 67 4) Review of R1's physician's orders showed that she was receiving Synthroid 125 mcg daily. Review of R1's labwork dated 1/12/07 showed that R1 had a low TSH level of 0.23 (norms=0.34 to 5.60). A review of a pharmacy recommendation dated 1/24/07 showed a comment from the pharmacist that R1's TSH level was found to be low at 0.23, indicating possible hyperthyroidism. The recommendation was to please consider decreasing the thyroid supplement to 112 mcg daily and re-check a TSH and T4 level in six weeks. The recommendation was not followed. No medication adjustment was done and no lab work was drawn to recheck the TSH and T4 levels. 5) R18 was admitted to the facility on 6/19/06 with diagnosis including Seizures, Hypothyroidism, Schizoid-affective, and Gastroenteritis Reflux Disease. During the medication pass observation on 3/18/07 at 4:00pm, E8 (LPN) was observed to administer Prozac 20 mg., Magnesium oxide 400 mg., Potassium Chloride 40 meq., and Trileptal 600 mg. to R18. E8 stated "R18 is supposed to receive Phenobarbital 20 mg. twice a day but I haven't given it to her for two nights because there is none available. I was unable to give it to her last night because it wasn't available. I ordered it from pharmacy. The pharmacy just delivered the medications for today but it did not come." As E8 was administering R18 her medications she experienced a seizure. At this time surveyor observed R18 standing in line for her medications. At this time she experienced seizure activity sustaining abrasions to both knees.	F9999		

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F9999	Continued From page 68 Review of R 18's Physician's Order Sheet (POS) and Medication Administration Record (MAR) dating from 2/15/07 through 3/18/07 showed R18 was to receive Phenobarbital 20 mg./5 ml. at 8:00 am and 4:00 pm. Phenobarbital is used to control Seizure activity. R18's POS's state to monitor Phenobarbital levels monthly. R18's Phenobarbital levels are as follows for 2/1/07 through 3/15/07: NORMAL LEVELS -15-40 2/2/07- 12 Low 2/5/07- 11.7 Low 2/16/07 - 14.6 Low 3/19/07- Normal (after surveyor found Phenobarbital was not available and R 18 had a seizure) Review of R 18's MAR's dating 1/15/07 through 3/18/07 R 18's Phenobarbital was missed on the following dates: 1/16/07- 1 dose 1/26/07-1 dose 1/27/07- 1 dose 2/21/07- 1 dose 2/28/07 - 1 dose 3/7/07- 1 dose 3/13/07- 1 dose 3/17/07- 1 dose 3/18/07- 1 dose During this time frame R18 was present in the facility, she was hospitalized Review of R18's nursing notes from 12/1/07 through 3/19/07 R 18 experienced seizures on the following dates:	F9999		

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F9999	Continued From page 69 12/1/06 with skin tear 12/5/06 without injury 12/20/06 with bruising to left ey 12/25/06 with laceration to back of head 1/1/07 without injury 1/2/07 without injury 1/07/07 without injury 1/20/07 without injury 1/24/07 without injury 2/2/07 injury to head 2/20/07 without injury 2/24/07 hematoma over right eye 3/11/07 without injury 3/13/07 head injury 3/17/07 without injury 3/18/07 abrasions to knees 3/20/07 without injury Interview with E3 (DON) on 3/19/07 at 11:00am, E3 stated she did not know about R18's Phenobarbital levels being low and all the missed dosages, but R 18's Seizure activity is hard to control. (A)	F9999		