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| F9999 | FINAL OBSERVATIONS<br><br>Surveyor: 08706<br>STATE VIOLATIONS ISSUED FOR THIS SURVEY:<br><br>300.1210 a)<br>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 each resident's comprehensive assessment and plan of care. Adequate and properly supervised | F9999 | | |

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nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.
Personal Care, as defined in section 300.330, is assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision and oversight of the physical and mental well-being of an individual who is incapable of maintaining a private, independent residence or who is incapable of managing his person, whether or not a guardian has been appointed for such individual (Section 1-120 of the Act).

This regulation was not met based on observation, medical record review, facility smoking policy review, incident report review, and staff interviews; the facility failed to supervise and monitor one resident (R5) on 7/4/2004. R5 was previously identified by the facility to have the behavior of smoking in non-designated areas. Because facility failed to supervise R5 in accordance to his care plan and the facility's policies for smoking and careless smoking, R5 caused a fire in the facility thus putting him and other residents in danger. Facility also failed to implement their policy and monitor other residents at risk of smoking in rooms as evidenced by surveyors' example of R8 noted while surveyor was conducting a facility tour.

Findings include:

An incident report dated 7/4/2004 at 6:38PM was reviewed. It documents that R5 had a diagnosis of paraplegia, seizure disorder, hypertension, gastritis and schizoaffective disorder. "Description of incident: resident set his mattress and bed linens with fire. Nursing Action/First aid: Resident room

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entered. The fire was curtailed with fire extinguisher; all other residents including R5 were transferred to the day room. Police called at 6:30PM and responded at 6:35PM."

E1 provided the surveyor with a letter that outlined the incident; it stated, in part: "On July 4, 2004, at about 6:38PM, the 4th floor nurse discovered that a mattress in room 401 was smoldering and the room was filling with smoke. The fire alarm was pulled, thereby alerting the fire department. The fire was put out using a fire extinguisher; it was determined that damage was limited to only the mattress of room 401, bed 3. R5 was assigned to that bed."

The only nurses' notes available for R5 were dated 7/4/2004, beginning at 6:35PM: "resident reported to the writer at the nurses' station that he got upset, he has stomach upset and wanted to go to the hospital. He was told to use his PRN (as needed) milk of magnesia and then I will call his doctor. Resident left the nurses' station for his room." The next entry is: "resident returned to his room and came out in his wheelchair for the dayroom and later returned to the elevator for the lobby." Then, at 6:38PM: the writer documents smelling something burning and alerted to start inspection of rooms. The charge nurse went directly to room 401 and saw fire burning the mattress of R5 and some clothes. The fire was brought immediately under control. Other charge nurses and security alerted from other floors. At 6:40PM: "911 called immediately while other residents were informed and transfer them to the day room." Notes timed for 6:45PM: "911 reported control of the fire unit, and policeman [name]. Everything was brought into control."

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| F9999 | Continued From page 12<br><br>The surveyor reviewed the staffing schedule for 7/4/2004 and conducted interviews with the facility's staff on duty at the time of the incident. According to the schedule for 7/4/2004 two staff members were assigned to the 4th floor unit. These staff members were interviewed.<br><br>E5 who was on duty at the time of the incident, was interviewed on 7/20/2004 between 1:40PM and 2:45PM, regarding the incident and the history of R5s' behavior. According to E5, the following took place on 7/4/2004: "I was on duty. I made rounds and I saw R5 in the bed. I saw the cigarettes and I told him not to smoke in his room. I came back to the nurses' station and I did my medication pass. R5 came to the nurses' station, the CNA was also present, and he was complaining about having an upset stomach. I told him I would call his doctor and give him Mylanta. The CNA requested to leave the floor. I told her to wait until I return from the bathroom and she did. So after she left, R5 came past the nursing station in his wheelchair towards the dayroom. Soon afterward I smelled smoke. I came down the hallway towards R5's room and the door was closed. I came into the room and saw the fire. I pulled the fire alarm and paged the nursing staff stating, "Come to the 4th floor-fire". I got the fire extinguisher and put it out. I saw R5 by a window and I yelled for a staff member to monitor him. The fire department came in about 5 minutes. The fireman sprayed the mattress again because there were still flames present. The police came. The detective came. I was interviewed twice about what had happened. The CNA was not on the floor at the time, she came back on the floor after the page over the phone for nursing assistance. The | F9999 | | |

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| F9999 | Continued From page 13<br>staff directed all residents on the floor to the day room."<br><br>E5 was asked if he knew R5 prior to the incident and E5 stated, "I knew R5 very well because he used to live on the 3rd floor. He usually smoked in the room against policy. Whenever I caught him smoking inside the room, I usually confiscated the cigarette and the lighter. He is aggressive and becomes more aggressive when you take the cigarettes. When he was on the 4th floor he had his cigarettes and lighter." This interview revealed that, on 7/4/04, staff did not confiscate smoking material and merely warned resident not to smoke in room.<br><br>E4 was interviewed, on 7/20/2004 between 3:25PM and 3:45PM, about the incident and R5's smoking behavior. The surveyor asked if R5 had a problem with smoking in the room and E4 stated, "Yes, we have had a problem with him smoking in his room so many times. We tell him not to, but he won't listen. He was only on my floor a week or two, when I saw him smoking in his room. I redirected him to go into the day room or stop smoking." When asked what had happened on 7/4/2004 involving R5 and E4 responded, "I was at the nursing station during documentation about a quarter to seven. R5 came to the nurses' station. The nurse, E5, was doing his duty. R5 complained about his stomach being upset. E5 told him he would call the doctor and give him some Mylanta. R5 left. I went to the ladies room (in the 1st floor lobby). I heard 'code red' and that it was on the 4th floor. I washed my hands and went back to the floor. Other staff was there taking residents to the day room. Smoke was present. R5 was in the day room." | F9999 | | |

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| F9999 | Continued From page 14<br><br>The surveyor interviewed the social service staff to discuss the inappropriate smoking behavior of R5 and what programs were in place for this behavior at the time of the incident. E12 was interviewed on 7/20/2004 between 1:18PM and 1:23PM; E12 stated he was in-charge of R5's social service needs after R5's return to the facility in June 2004. According to E12, R3 had a few incidents of smoking in his room. Nursing staff usually documented in the chart. Since his readmission of June 2004, no behavior of smoking in inappropriate places was noted until the incident. R5 had complaints about his work program, his room and roommate. E12 stated, he was present the day of the incident. E12 told the surveyor R5 reported to him, he was smoking in his room and put a cigarette butt out then the mattress was on fire. R5 did not alert staff to the mattress burning and had left the room. E12 also reported R5 refused to be in a one-to-one smoking program. R5 received individual counseling about smoking in inappropriate areas. R5 had access to the community and smoking materials were available to him."<br><br>E8 was interviewed on 7/20/2004 between 2:50PM and 2:54PM. E8 stated he was involved in the care of R5 since late May 2004. E8 was asked if he had any knowledge of R5 smoking in inappropriate places and E8 stated the nurse staff made him aware of R5 smoking in inappropriate places. E8 recalled a time when he entered R5's room for a one-to-one session, and saw cigarettes in a cup with water in it. E8 gave R5 one-to-one counseling about smoking in his room and reminded him about where the appropriate areas to smoke were located. | F9999 | | |

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| F9999 | Continued From page 15<br><br>On 7/21/2004 the surveyor interviewed R5 via phone, R5 now resides at another facility, R5 told the surveyor he went to the nursing station to ask about being transferred to another facility. E5 told him to go to his room. R5 reported he was smoking in his room and fell asleep. R5 told the surveyor he did not know where the cigarette was when he woke up, nor did he see any fire or smoke. R5 reported he woke up, got out of bed and went to the day room (on the 4th floor). R5 left the day room to go toward the nurses' station and overheard E5 yelling out "fire, fire, fire." R5 saw smoke in the hallway. The fire and police department came.<br><br>R5's care plan, dated 4/23/2004, identified: The resident demonstrates non-compliance with safe smoking regulation as evidenced by: Smoking in resident rooms, bathrooms, hallways, stairwells, elevators and other non-designated areas. Goal/objectives: Resident will demonstrate compliance with safe smoking policies as evidenced by not smoking in his bedroom or non-designated areas 5 times week and will comply with all rules and policies regulating smoking through the next review on 7/23/2004. Approaches /interventions include: conduct a smoking safety assessment as necessary. Provide appropriate smoking management in accordance with the assessment. Explain the consequences outlined in the policy for smoking policy non-compliance. This includes removal of all smoking materials and only being allowed to smoke when supervised. Remind the resident that staff will be observing and closely supervising smoking-related behavior. Non-compliance is to be documented in the medical record. If the | F9999 | | |

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| F9999 | Continued From page 16<br>resident is continually non-compliant with safe smoking policy, remove all of his/her smoking materials and place the resident on supervised smoking pursuant to the facility policy<br><br>The facility's smoking policy reveals that the smoking policy for careless smokers is: the facility will not allow careless resident to keep cigarettes or matches. Facility staff will supervise residents during smoking time. Smoking will not be allowed in the resident's rooms, bathrooms, hallways or the lobby. The designated smoking areas will be the 3rd and 4th floor dayrooms, also on the patio if weather permits, and when the door is not locked. Residents will have to obtain cigarettes from an appointed person in order to smoke.<br><br>The smoking policy reveals the following steps will be taken before resident is placed under supervised smoking:<br>1st offense - verbal counseling and redirection to designated smoking area.<br>2nd offense - verbal counseling and verbal reminder of designated smoking areas.<br>3rd offense - verbal counseling and written agreement/acknowledgment that resident knows designated smoking areas.<br>4th offense - resident will be placed in the smoking cessation program.<br>5th offense - resident is placed under supervised smoking.<br><br>On 07/19/2004, the surveyor requested a list of problem smokers. The facility provided a list of residents titled "residents needing supervision with smoking"; R5 was among the listed residents. | F9999 | | |

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| F9999 | Continued From page 17<br>On 7/20/2004 the surveyor did random observations on the facility's 4th floor. At 1:15PM, R8 was observed smoking in the facility's bathroom. At the time there was only one staff on the unit, E10 who was not in the immediate area where R8 was smoking.<br><br>E10 was interviewed by the surveyor and stated, "(R8) knows they are not to smoke in there. If the dayroom was being cleaned, they are supposed to go to the 3rd floor." The surveyor asked E10 if E10 ever saw R5 smoking in inappropriate places and E10 stated, "I've seen him smoke in his room. I saw him smoking in his room 3 times. Each time he was caught smoking in the room, he would be told not to do so but continued."<br><br>( A )<br><br>* * * * * * * * * * * *<br><br>Complaint investigation 0483065/IL11429 No findings<br><br>IRI of 7/4/2004/ IL11640 Refer to F324. | F9999 | | |