STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145942	A. BUILDING _____ B. WING _____	C 04/14/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEALTH AND REHAB CENTER	**9525 SOUTH MAYFIELD OAK LAWN, IL 60453**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 492	Continued From page 8	F 492		
F9999	. FINAL OBSERVATIONS LICENSURE VIOLATION 300.1210a) 300.1210b)6) 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 b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 6) All necessary precautions shall be taken to 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 Regulations were not met as evidenced by:	F9999		

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F9999	Continued From page 9 Based upon observations, record reviews and interviews the facility failed to effectively implement and follow their policy and procedures regarding smoking by a non-compliant residents for 1 (R1) of 4 residents in sample. R1 on 4/2/09 was found smoking in his room and suffered burns. This failure to supervise resulted in hospitalization. Findings Include: 1. R1 was admitted per record review of the admission record with a diagnosis of DMII (Diabetes Mellitus Type 2), Diabetic Retinopathy NOS (Not Otherwise Specified), Malignant Hypertension; Femoral Vein Phlebitis, Amputation Leg Bilateral. and Amputation Above Knee Unilateral." Review of R1's MDS (Minimum Data Set) dated 3/25/09 denotes limited assistance required in transferring, and does not ambulate but uses wheelchair for locomotion. R1's smoking assessment dated 3/30/09 depicts the following (Codes O=no problem, 1=minimum problem, 2=moderate problem, 3=severe problem): R1 was coded a 3 (severe problem) under "Smokes in unauthorized areas; careless with smoking materials; drops cigarettes butts or matches on floor; furniture, self or others; burns finger tips; smokes near oxygen. Potential for safely following the facility safe smoking policy." R1 was coded a 2 (moderate problem) under "Begs or steals smoking materials from others; general awareness and orientation, including	F9999		

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F9999	Continued From page 10 ability to understand the facility safe smoking policy, general behavior, and interpersonal interaction." The facility failed to implement their Resident and Visitors Smoking Policy that denotes all residents shall smoke only in designated areas, and those residents that pose a hazard with smoking materials will have supervised smoking times provided for, and may be placed in a supervised program for safe smoking. E2 (director of nursing) reported R1 did not have specific/designated times; or a supervised program for safe smoking provided. The nurses notes dated 4/2/09 at 2:45pm denotes the following: "R1 was found in room by am housekeeper with large amounts of smoke in the air. Housekeeper made charge nurse and CNA aware. Upon entering room. O2 (oxygen) per NC (nasal cannula) on resident stuck to sides of head due to smoking while O2 per NC in progress. resident taken out of the room to nurse station. O2/NC started. VS (vital signs) B/P-90/66; R24; P72; T.97.3. Tylenol ES (extra strength) given PO for pain, 911 called." E5 (nurse) was interviewed on 4/7/09 at 2:30pm and identified herself as the writer of the above note stating, "R1 has a history of smoking, we have caught with cigarettes and lighters, taken from him. Last time R1 returned from hospital decreased mental status. We (also E6/certified nurse aide) responded to E4 (housekeeper) calls. We removed R1 from room to nurses station. R1 burned around mouth, nose, hair from side of face, eyebrows, fingers were blackened. I gave R1 oxygen, and called 911, assessed pain, and	F9999		

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F9999	Continued From page 11 sent R1 out." E6 (CNA/certified nurse aide) was interviewed on 4/7/09 and stated, "R1 had a history of smoking with mask oxygen on and was not compliant on smoking." E4 (housekeeper) was identified by E2 (Director of Nursing) as the person that found R1. E4 was interviewed on 4/7/09 at 1:58pm and stated, "I was walking down the hall and R1 called out E4, E4, Fire, and I ran in room and put fire out that was on floor. The cord to tank was burning, and I took R1 to door, and called for staff to come help. I stepped on it (fire) with my feet and put it out on the floor. It was a lighter in drawer, and I checked the drawer and removed the lighter from the drawer." E2 (director of nursing) was interviewed on 4/7/09 and stated," R1 is now at hospital, I found on floor O2 (oxygen) cannula, I took a picture of it. R1's hair on side of face singed off." E2 gave surveyor a print of the picture on 4/8/09 at 9:00am stated," I took this picture of the burned O2 cannula on the floor." The picture upon review depicts a blackened item. E3 (MDS-NCPC/minimum data set/nursing care plan coordinator) was interviewed on 4/7/09 and stated, "I was on the 1st. floor in E7's (social worker) office talking with E7; and E1 (administrator) busted through the door of E7 office and said R1 was trying to smoke and set himself on fire. Then me and E7 ran upstairs. R1 was at the nurses station and respiratory was there. I asked what had happened and R1 would not answer."	F9999		

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F9999	Continued From page 12 E7 (social worker) on 4/8/09 reported R1 was not compliant with the facility smoking rules. The Social Service/Progress Note dated 4/2/09, and confirmed by E7 as the writer, reflects the following: "Incident behavior note: Today R1 was found in room smoking w/ (with) a fire. R1 was in his room attempting to smoke w/ his O2 mask on which caused the tubing to catch fire." R1 was taken via ambulance on 4/2/09 to a local hospital, and per E8 (treatment nurse) R1 died on 4/10/09. (A)	F9999		