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	14E506	A. BUILDING _____ B. WING _____	C 10/08/2009

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F 323	Continued From page 7 Psychosocial Service Director will monitor compliance to this change. 2) Frequency of random searches of residents rooms for contrabands by managers were increased to daily searches starting 10/8/09. The Administrator will monitor staff compliance with these searches as part of QA process. 3) Residents' families will be used as source of residents' psychosocial history information to identify additional risk factors including smoking and fire-setting behaviors. This was initiated 10/7/09 and Psychosocial Service Director will monitor compliance as part of QA process. 4) The resident review of smoking rules was conducted on 10/3/09 and will be an ongoing process on a quarterly basis. 5) A fire drill was immediately conducted by the Administrator and Environmental Service Director on 9/15/09, to ascertain if all facility systems were fully operational. A fire safety in service was also conducted on 10/6/09 by Administrative Assistant and Environmental Services director and will continue on a quarterly basis.	F 323		
F9999	. FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)3) 300.1210b)6)	F9999		

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F9999	Continued From page 8 300.1220b)3) 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's	F9999		

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F9999	Continued From page 9 comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. These requirements were not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to provide supervision to one resident (R3) with a history of noncompliant smoking behavior in the sample of four. R3's treatment plan was not updated to reflect smoking behavior and provide for specific monitoring and individualized supervision of R3 and the use of smoking materials. R3's roommate saw R3 leaving his room while a fire was burning on the floor by R3's bed at 1:45 AM on 9/15/09. This failure has a potential to affect the residents on the 1st floor. Findings include: R3 was admitted to the facility on 4/29/09 with diagnoses of Bipolar Disorder, Schizoaffective disorder, and Suicidal Ideation. Per incident report dated 9/15/09, at 1:45 AM, R3 started a fire in his room that left smoke residue on the floor and burnt part of the clothes cabinet by R3's bedside. According to R2 (during 9/30/09 interview at 3:45 PM), on 9/15/09, he woke up in	F9999		

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early morning smelling smoke in their room, and saw R3 bolting out of the door naked. R2 continued that when he got to the door, their toilet was smoky and he saw a fire burning on the floor and in front of R3's cabinet, next to R3's bed. R2 added that he put out the fire by throwing several cups of water at it from the faucet. R2 said that the staff is aware R3 smokes in his room and that he even saw R3 smoke in bed several times. When E4 (11-7 nurse) was interviewed on 10/1/09 at 7:20 AM, E4 said that when she called R3's mother to notify her of the incident, the mother said that R3 set a fire in another facility before.

On 9/30/09 at 3:45 PM, the floor area where R3 had supposedly set a fire, was noted as a circular area with melted burnt black residue that is still stuck on the floor. The area was in between the wall and R3's bed which was right next to the door. The cabinet was already removed by the facility.

Per nursing notes, behavior sheets and treatment plans, the facility was fully aware of R3's noncompliance with the smoking policy. While at the facility, according to nurses note dated 5/29/09, at 5:00 AM, R3 was seen disoriented and with red eyes. According to the notes, R3 verbalized at the beginning of the shift that he smoked marijuana in his room. R3 and R3's room had a significant smell of marijuana that correlated with his story when staff checked out his room. Search indicated that a cigarette, two cigarette butts, and a lighter were found in R3's possession at the beginning of the shift.

On 6/9/09 at 9:00 AM, R3's nurses notes also indicated that R3 verbalized, "You'll making me

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want to run away cause I can't smoke when I want to" and that case worker was aware of his inappropriate smoking. No further explanation was found if R3 was caught smoking or where it happened, or if R3 was searched and if smoking materials were found.

R3's nurses notes dated 7/3/09 at 3:00 PM indicated that a smell of burnt paper was coming from R3's room, although no paper or lighter was found in R3's possession or in his bathroom.

On 8/22/09 at 9:00 PM, R3 also pulled the facility's fire alarm according to his nurses notes. Per R3's Behavioral Occurrence assessment dated 8/22/09, R3 said he pulled the fire alarm because he wanted to see fire. During 10/1/09 interview at 2:30 PM, E10 (case worker) confirmed that R3 said he wanted to see fire when asked initially. E10 said that R3 verbalized he does not know why he pulled the fire alarm, when E10 asked him the second time. This was not followed up by E3 (Case Director) until two days later, and there was no indication that R3's verbalization of wanting to see fire was communicated to the nurse for referral to the psychiatrist to evaluate R3's statement or intention further. E10 said he cannot remember if he told the nurse about R3's statement on his desire to see fire.

R3's Behavioral Occurrence Assessment dated 5/4/09 also showed that on that day at 11:05 AM, the nurses aide smelled cigarette smoke in his room and R3 was told that he cannot smoke in the room. This note also indicated that 1:1 verbal intervention was not effective with R3 as R3 did not respond while the staff was talking to him. There was no indication that R3 or his room were

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searched or if his smoking paraphernalia was confiscated, as the box corresponding to these interventions were not checked as done. Furthermore, it was not indicated what was done next as the intervention mentioned was noted as ineffective.

During 10/1/09 interview at 11:57, E9 (nurse aide) also verified that one time she smelled smoke in R3's bathroom, although no cigarette or match/lighter was found. E9 also said that R3 would pick cigarette butts.

Interview with E5 (R3's case worker on the 4th floor during initial admission) on 10/1/09 at 2:00 PM showed that there were other instances when R3 had incidents related to smoking in unauthorized areas. These were not reflected anywhere in R3's records. E5 said that R3 was busted for smoking in his room, placed cigarette butts under his mattress, and on one occasion, left ashes on the floor in his room without intention of hiding it. E5 continued that R3 would leave the facility and come back and try to smuggle cigarette and marijuana inside. E5 said that she thinks that R3 gets his smoking materials from outside or from other residents inside the facility.

Review of R3's smoking care plan dated 5/2/09 indicated that it was not updated when R3 had a quarterly MDS (Minimum Data Set) assessment on 8/11/09. Furthermore, during interviews, it cannot be determined by the facility who was R3's case worker during this period who should have reviewed, reassessed, and updated R3's care plan on smoking. E8 (1st floor case manager) said during 10/1/09 interview at 11:45 AM, that she only had R3 in her case load for a

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F9999	Continued From page 13 short time, as R3 initially was on another floor of the building. E8 said during her time with R3, she did not update his care plan nor did she remember a care plan conference by the facility interdisciplinary team to discuss R3's care during his 8/11/09 MDS period. Additionally, each time R3 is caught with smoking behaviors contrary to facility's policy, this was not reflected in his care plan and interventions were not evaluated and revised if they are not effective in preventing R3's access to smoking materials and R3's smoking in unauthorized areas of the facility. Per R3's outdated care plan done for the period 5/2/09 to 8/2/09, if R3 is caught smoking in unauthorized area, all smoking material will be confiscated and R3 will be placed on observation. Added to this, another intervention is to remind R3 of the smoking policy and procedure. When E3 was interviewed on 10/1/09 at 11:30 AM, E3 explained the smoking policy of the facility: Upon admission, residents are assessed using the Safe Smoking Risk Assessment, given orientation of smoking schedules and designated areas, and are asked to sign a smoking contract. E3 said that all smoking materials (tobacco, cigarette , matches, lighters, etc) in the facility are kept by smoking monitors, and handed to residents during smoking periods at designated areas. Even residents with unsupervised community passes are not allowed to keep their own smoking paraphernalia. E3 continued that upon entry to the facility, residents are searched to ensure they do not have in their possession, smoking materials. If caught smoking unsafely or smoking in unauthorized areas, smoking materials are confiscated, the resident is reeducated, and behavior is addressed. E3	F9999		

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F9999	Continued From page 14 added that random search for smoking material is also done. Although R3 has a history of not following the smoking policy and continuing to smoke in unauthorized areas, there was no indication that the facility is actively providing interventions to ensure R3 does not have in his possession smoking materials. Several times R3 was noted to be smoking in his room and staff were not able to prevent his access to cigarette, marijuana, and lighter or matches. Added to this, as indicated above, there was an instance where no resident or room search was done after R3 was caught smoking in his room on 5/4/09. The facility failed to provide interventions and or a care plan to ensure that R3 is without smoking material. Times of monitoring and observations are not clearly defined on R3's treatment plan. A specific plan of how often the search for smoking materials is done for R3, who had been exhibiting continued smoking in unauthorized places was not developed. R3's record indicated that in some instances, the searches were done when there is a smell of smoke in R3's room, but there was no sign of any random search to determine possession of matches/lighter/cigarettes on R3. In addition, the facility was aware of R3's behavior from information provided by the previous facility. Per R3's previous facility records, R3 was noted to be noncompliant with facility's smoking policy on numerous occasions and was caught by staff doing so. There was no individual plan noted as how to address this issue and supervise R3 to prevent access to this smoking materials or monitor him for possession of such. R3's 8/11/09 MDS indicated that R3 resists care and this behavior is	F9999		

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F9999	Continued From page 15 not easily altered. (A)	F9999		