

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/25/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145625</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/04/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>CALIFORNIA GARDENS N &amp; REHAB C</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2829 SOUTH CALIFORNIA BLVD CHICAGO, IL 60608</b>		
(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 425	Continued From page 25 contained several one liter bags of intravenous fluids as well as 4 intravenous bags of antibiotic medications (Zosyn 4.5 Grams) for R32 who was discharged 10/13/09. When E19 (Assistant Administrator) was questioned about the disposition of discontinued medications, he said that they were kept in case the same medication is ordered for another resident, or the same resident returns to the facility.	F 425			
F9999	FINAL OBSERVATIONS  LICENSURE VIOLATIONS  LICENSURE VIOLATIONS  300.1210b)6) 300.3240a)  Section 300.1210 General Requirements for Nursing and Personal Care  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.  Section 300.3240 a) Abuse and Neglect  a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.  These Regulations were not met as evidenced	F9999			

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F9999	<p>Continued From page 26</p> <p>by:</p> <p>Based on observation, interview and record review, the facility failed to follow facility policy to take progressive steps of restricting smoking privileges for one resident (R8) involved in unsafe smoking practices in the sample of 30 residents.</p> <p>Findings include:</p> <p>R8 was observed lying in bed on 10/22/09 at approximately 12:30 PM while eating lunch. R8 had both siderails up and a sheet covered his lower body. It was apparent that the right leg had been amputated. When questioned about a prosthesis, R8 stated that he had not been fitted for one yet. R8's mode of locomotion is by wheelchair. When R8 was interviewed on 10/22/09 at 1:00 PM about smoking in bed, he stated, "I used to do that, but not anymore since I burned myself." At 2:45PM, the surveyor and E22 (nurse) observed R8's chest. The resident's chest was observed to have a circular wound on his chest and an approximately 3 inch long wound on his chest and what appeared to be singed chest hairs.</p> <p>R8 is a 68 year old resident who was admitted to the facility in 2005. R8's diagnoses include Major Depressive Disorder, Seizure Disorder, Cerebral Vascular Accident with Right-Sided Weakness, Diabetes Mellitus and Right Above the Knee Amputation in April, 2009. R8 is alert and oriented to person and place with periods of confusion. Review of the resident's chart indicated that since admission, R8 has a history of smoking in inappropriate places in the facility and often becomes verbally abusive when redirected, or denies the act. In the resident's</p>	F9999			

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F9999	<p>Continued From page 27</p> <p>medical chart, the 10/16/09 Social Service note by E13 (Psychosocial Rehab Coordinator) said that E13 had been informed that R8 had cigarette burns on his chest. The note further explained that, "The resident would get fellow residents to light his cigarettes for him and he would smoke them lying down and burn his chest." The nurse's note for 10/19/09 said that the resident was observed with burn marks from cigarettes that caused open areas to chest. Also stated was that the physician was being notified of the burn. The 10/19/09 Physician Order Sheet (POS) showed a phone order for the open areas on the chest to be cleansed with normal saline then an antibiotic ointment to be applied twice a day until healed. The social service note for 10/21/09 stated that R8 had again been smoking while lying down in bed. E13 documented that the cigarettes were confiscated this time.</p> <p>Review of R8's medical chart indicated that this resident was observed or suspected of smoking in his room on these dates: 6/10/09, 6/18/09, 7/9/09, 7/22/09, 8/5/09, 8/13/09, 8/19/09, 9/09/09, 9/25/09, and 9/30/09. The interventions included counseling the resident and sometimes searching for smoking materials. When E13 was interviewed on 10/22/09 at 1:15 PM, she stated that a resident is counseled if found or suspected to be smoking in his room and the room is searched. E13 also showed the surveyor the cigarette packet that was allegedly confiscated from R8 on 10/21/09.</p> <p>On 10/22/09 at 1:30 PM, E15 (Nurse) was asked about where R8 obtained his cigarettes. E15 stated that cigarettes are issued by the Activity Department staff because R8 is in the smoking program. On 10/22/09 at 1:40 PM, E14 (Director</p>	F9999			

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F9999	<p>Continued From page 28</p> <p>of Activity Department) stated that R8 is issued 5 cigarettes between 9-9:30 AM and 5 cigarettes between 2-3:00 PM each day. When questioned about the concern of R8 having cigarettes, E14 said that R8 can have the cigarettes as long as he is not given a lighter or matches.</p> <p>Review of the facility Smoking Policy states: 3. There is absolutely no smoking permitted in any resident bedroom or bathroom. 4. All residents are expected to abide by the smoking rules. Smoking is a privilege not a right and smoking privileges will be withdrawn should they not be followed. The policy further states: <b>PROGRESSIVE STEPS OF RESTRICTING SMOKING PRIVILEGES</b> For all residents of California Gardens whom do not follow smoking rules there is a progressive removal of smoking privileges. The policy cites progressive steps of restricting smoking privileges if the rules are broken. The first infraction involves a one time verbal warning. On the second infraction, the resident will not be permitted to have any smoking items in their possession. Distribution of cigarettes by staff will be one cigarette at a time for a period of 2 weeks. upon the third infraction, much of the second applies and resident may be supervised. Further, at each 90-day time period, a resident can petition the Interdisciplinary team in writing to have their smoking privileges reinstated. It would take approval of 3/4 of the team to reinstate smoking privileges.</p> <p>(A)</p>	F9999			