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CEDAR POINTE REHAB & NURSING	**5825 WEST CERMAK ROAD CICERO, IL 60804**

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F 323	Continued From page 14 8. 75% of staff in-services are projected to be completed by 2/22/2011. The remaining 25% will be completed by 2/28/2011. The titled in-services to be completed a. Revised smoking policy b. Search/Rounds protocol The Facility Administrator will monitor for overall compliance.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210a) 300.1210b)6) 300.1220b)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated there under. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care	F9999		

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F9999	Continued From page 15 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. Restorative measures shall include at a minimum the following procedures: b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven days 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 300.1220 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 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	F9999		

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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 observation, interview and record review the facility failed to provide supervision and monitor 1 sampled resident (R2) identified with a history of smoking in inappropriate places. This failure resulted in R2 causing a fire in her room. As a result of the fire, R2 and R9 were transported to the hospital for evaluation of smoke inhalation. The facility also failed to assure residents' floors and residents' access areas, including stairwells and bathrooms, were monitored for smoking by staff. The facility also failed to ensure that R9 identified with unsafe smoking behaviors was reassessed for safe smoking behaviors.

These failures have the potential to affect 311 residents currently at the facility.

Findings include:

On 2/10/11 at 12:00 p.m., E1 (administrator) said that at 3:20am on 2/10/11 he was notified at home by security that there was fire on the 6th floor at the facility.

According to the facility's unusual occurrence report dated 2/10/11, R2 was observed running out of her room yelling fire, fire everybody needs to get up and go home. R2 was assessed as confused, vital signs were assessed: blood

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pressure 128/76, pulse rate 84, respirations 18, and temperature 98.3. The management's follow-up to the incident indicated that R2 was in her room and a fire just started by her bed. She also stated that she was mad at another resident. R2 was placed on 1:1 intervention to prevent injury to self, and others. The follow up denotes that R2 was sent to the hospital for evaluation and smoke inhalation.

On 2/10/11 at 12:45pm with E3 (Assistant administrator), Room 623 was observed to have water on the floor, and a mattress which appeared to have been burned (black in color and the cover of the mattress appeared to be melted). E3 said the mattress belongs to R2. The mattress was moved to the other side of the room. On R2's side of the room there was a pile of burned damaged clothing black and destroyed. The privacy curtain was burned and melted up to the ceiling.

On 2/10/11 at 2:00pm, E1 said that R2 had been sent to the hospital for a psychiatric evaluation, and was unavailable for observation or interview. E1 said that no other residents were sent out to the hospital related to the fire. E1 said that R2 had two roommates both still in the facility.

On 2/10/11 at 3:45pm in the 8th floor break room, R3 said that she was R2's roommate. R3 was assessed to be alert and oriented to person/time. R3 said that around 3:00 a.m. on 2/10/11 she heard her roommate R2 yelling fire, fire. R3 said that she observed flames coming from under R2's bed along with a lot of smoke. R3 said she was told to get out of the room. R3 said that she has been the roommate of R2 for about 10

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months. R3 said that R2 has a history of smoking in the room at night after the smoke room closes. R3 said that she did not report it to anyone but said that staff has come in the room saying that they smell smoke. R3 said that the experience was scary. R3 said that she feels okay and can breathe fine.

On 2/10/11 at 4:05pm in the 8th floor break room, R4 said that she is the roommate of R2, and has been the room mate for about 3 to 4 months. R4 said that at around 3:00am on 2/10/11 she was awakened by R2 yelling there was a fire in the room. R4 said that she grabbed some things and got out of the room. R4 said that she did not see R2 smoking in the room that morning, but did say that R2 smokes in the room every night after the smoke room closes on the first floor. R4 said that she has not reported it to staff, but said that staff will come in the room checking because they smelled smoke.

According to R2's clinical record, R2 was last assessed for smoking safety on 6/21/09. R2 was assessed as having potential for causing injury to self, or others in unauthorized area or careless use of smoking materials. R2 was also assessed to be a potential risk for safely following the facility's safe smoking policy. The assessment indicates that R2 has no history of hazardous and inappropriate behaviors. The comments indicate that R2 has been redirected for inappropriate smoking. A review of R2's plan of care indicated that R2 was assessed to have impaired judgment related to mental illness, a nicotine dependency, and compulsive smoking. R2's plan of care failed to indicate any interventions to monitor or supervise R2, and to

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F9999	Continued From page 19 keep R2 and others safe related to R2 being identified with a history of inappropriate smoking. Social service notes dated 2/10/11 indicate that R2 was smoking in her room in the early morning hours, and her bed caught on fire. According to social service notes dated 12/31/10, and 1/31/11, R2 has a history of smoking inappropriately. The notes were written by E11. On 2/11/11 at 5:40pm, E11 (social service) said that R2 has a history of smoking in inappropriate places, but cannot recall R2 being observed smoking in inappropriate places recently. E11 said that staff is required to make rounds every 2 hours to check for inappropriate smoking. E11 said that residents assessed for inappropriate smoking are listed on the facility's smoking program. E11 said that R2 is not on the smoking program list. E11 said residents are not allowed to have smoking material on their person including cigarettes, matches, and lighters. E11 said that residents are assessed for smoking appropriateness at admission, annually and quarterly. E11 said that he has only been assigned to R2 since January, 2011. E11 said that he has not assessed R2 for smoking since he has taken over R2's case. E11 said that R2 goes out into the community on pass, at times. E11 said that security is expected to search residents upon returning to the facility. E11 explained that the facility smoking program is for residents that are assessed or observed to have unsafe smoking behaviors or smoke in inappropriate places. On 2/16/11 via telephone, E7 (licensed nurse) said that around 3:00 a.m. he was told by E8	F9999		

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(certified nurse aide) that she smelled smoke. E7 said then he heard the fire alarm ring. E7 said that he received a call from security stating that [R2's room's] smoke detector was alarming. E7 said that as he went to the east hallway R2 was running out of [R2's room] yelling fire, fire. E7 said that R2 was delusional as she was running out of the room. E7 said that he looked into [R2's room] and yelled for R3/R4 to come out of the room. E7 said that all residents were initially evacuated to the first floor except for R9 in [R9's room]. E7 said that he observed R2's mattress engulfed with flames and a box of clothing also on fire under R2's bed. E7 said that he inhaled a lot of smoke and notified the fire department to get R9 out of [R9's room]. E7 said that after accounting for all residents he put R2 on 1:1 monitoring, and E7 said that R2 did not say how the fire started. E7 said that he has caught R2 with smoking materials before, and said that he confiscated the materials from R2. E7 said that when a resident is found with smoking materials they are referred to social service for counseling and assessed for inappropriate smoking. E7 said he recalls confiscating cigarettes and a lighter from R2 sometime this year (2011). E7 said he did not recall if he referred R2 to the social service department. E7 said that residents are not allow to smoke after 11:00 p.m. and can restart smoking at 8:30 a.m. daily. E7 said that at times he works with 1 or 2 certified nurse's aides, but on 2/10/11 there was only one certified nurse's aide working with him on the 6th floor unit. E7 said that he was aware that certified nurse's aides are required to make rounds every 2 hours to check to see if the appropriate resident is in the correct rooms, smoking and any loud noises.

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E7 said that he was aware that some point R2 was assessed for inappropriate smoking, but lately R2 was not observed smoking in inappropriate areas. E7 said there was no safety measure in place for R2 on 2/10/11 other than rounding. E7 said that he recalls speaking with R4 (R2's roommate), and was told by R4 that she smelled cigarettes scent coming from R2's area of the room.

On 2/23/11 at 11:00am via telephone, E8 (Certified Nurse's Aide) said she did rounds at 11:00 p.m. on 2/9/11 to ensure that all resident were in the appropriate rooms. E8 said as she made rounds she could smell smoke in the female washroom. E8 said that when she entered the bathroom R2 was observed in the washroom with a scent of cigarette smoke. E8 said that R2 was observed with no smoking materials. E8 said she made rounds again at 2:00 p.m. and R2 was in her bed with the cover over her head. E8 said she returned to the nurse's desk to complete paper work. E8 said about 3:00 a.m. the alarm sounded, it was identified as being in [R2's room]. E8 said that as she and the nurse went to see what was going on, black smoke was noted coming from R2's room. E8 said that R2 and roommates were running out of the room. E8 said that R9 was in [R9's room] and the heavy smoke made it impossible to get to R9 in [R9's room], but said that the fire department was directed to the room. E8 said that R2 has a history of unsafe smoking. E8 said that she has observed R2 smoking in other residents' room. E8 said that R2 is also known to have smoking materials on her person, contrary to the facility policy. E8 said that she makes rounds on the unit every 2 hours.

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On 2/18/11 at 12:55 p.m., E12 (security director) said that in general, security asks residents when returning to the facility if they have smoking materials on them. E12 said if a resident is identified as an unsafe smoker, they will pat their bodies down. E12 said that there is one female security officer on staff, and when she is working she checks female residents. E12 said that R2 has a history of bringing smoking materials into the facility. E12 said that R2 hides material in her vaginal area.

During a tour of the facility on 2/10/11 of the 7th and 8th floor, cigarette ashes and cigarette butts were observed on the floor of both the east and west bathroom. While touring the facility, cigarette butts were observed in the stairwells of both the 7th/8th floors. E3 and E5 were present during the tour. During the tour at 1:30 p.m., E3 said that this is psyche facility and we do our best.

According to the hospital records dated 2/10/11, E9 was admitted to the hospital with mild asymptomatic smoke inhalation.

On 2/10/11 at 5:30 p.m., E3 (social service director) said that staff are required to do rounds on the nursing units every two hours and complete the facility's smoking rounds log. On 2/10/11 the facility was unable to provide the survey team with current smoking rounds for the 6th floor. A review of the smoking rounds log sheets for the 6th floor, the last one noted to be complete was 2/4/11. On 2/18/11 at 10:00 a.m., E3 said that the facility was unable to locate the missing smoking round sheets. However, E3 did

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F9999	Continued From page 23 provide surveyor with a new revised smoking assessment, and safe smoking round sheet. According to the facility's smoking policy denotes the purpose of the policy is to promote and protect the safety and welfare of the facility's resident. The policy also indicates that facility staff will identify residents observed or assessed as exhibiting unsafe/inappropriate smoking behaviors and assign them to the smoking program. Once assigned to the smoking program, residents identified as exhibiting inappropriate and/or unsafe smoking behaviors will be placed on smoking rounds. The policy also denotes that no resident will be allowed to keep smoking materials on his/her person, or in their rooms. The policy also denotes the facility will provide a designated smoking area, and all residents smoking will be monitored. (A)	F9999		