		AND HUMAN SERVICES					APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO.	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) N	/ULT	IPLE CONSTRUCTION	(X3) DATE SU	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDI	NG	COMPLE	
		445000	B. WI	NG			С
		145636				11/3	0/2011
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CHARLE	STON REHAB & HEA	ALTH CARE CENTER					
					CHARLESTON, IL 61920		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREF	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO		(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPR		DATE
-					DEFICIENCY)		
-			_				
F 000	INITIAL COMMEN	IS	F	000			
	Investigation of 11	-19-11 Incident (IL55405)					
	A partial extended	survey was conducted.					
F 323		-	F	323			11/30/11
SS=K	()		•	020			,
		nsure that the resident					
		ns as free of accident hazards					
		each resident receives on and assistance devices to					
	prevent accidents.						
	F						
		NT is not met as evidenced					
	by:						
		tion, record review and					
		staff failed to remove a liquid					
		annula from R1 prior to					
		ke. This resulted in R1's					
		niting causing complex facial and placing the other					
		R2, R3 and R4) at risk of					
	injury. R1, R2, R3,	and R4 are 4 residents					
	reviewed for smoki	ng safety in the sample of six.					
	This failure resulted	d in an Immediate Jeopardy.					
		d the immediate jeopardy on					
		ains out of compliance at a					
	for the effectivenes	ne facility continues to monitor					
		evised policy implementation					
		safety and oxygen use.					
	The findings include	e:					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 02/22/2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		145636	B. WI	NG_			C 0/2011
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
CHARLE	STON REHAB & HEA	LTH CARE CENTER			716 EIGHTEENTH STREET CHARLESTON, IL 61920		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323	Continued From pa	ge 1	F	323			
	report to the State S Agency Regional O outside to smoke w causing a flash burn Investigation initiate	cility faxed an initial incident Survey and Certification Iffice which stated "Resident ith oxygen on, cigarette lit n November 19, 2011. ed and final report to follow."					
	the facility on 11/08 Service History and that R1 was 64 yea his apartment in the "resident says he no to come (to the faci	Admission note documented Admission note documented rs old and was admitted from e community. Notes document eeds nursing care and wants lity) to get better. Resident has nd gets winded easily".					
	Physicians Order S obstructive pulmona R1 had 11/08/11 or Occupational therap admitting physiciana	nosis on the November 2011 heet was COPDE (chronic ary disease excacerbation). ders for Physical and py for 30 days. R1 had an s order for Oxygen at 2 liters I cannula PRN (as needed).					
	documented R1 wa limited assistance of ambulation, and wa mobility. The asses resident expected to	a Set (MDS) dated 11/21/11 as cognitively intact, required of one staff for transfers and as independent in wheelchair asment documented goal was o be discharged to the careplan team had also feasible for R1.					
	documents "Nurse acquired facial burn	dated 11/19/11 6:40 pm on duty notified that (resident) ns when outside smoking with On call nurse (E3) instructed					

	T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CONSTRUCTION	(X3) DATE S). 0938-039 SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD		COMPL	
		145636	B. WING			C
	PROVIDER OR SUPPLIER	145050				30/2011
	STON REHAB & HEA	ALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 716 EIGHTEENTH STREET CHARLESTON, IL 61920	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 323	nurse to transfer re 911." Notes of 11/ R1 was on a ventila via helicopter. The resident was intuba soot accumulation acquired 2nd and 3 2nd degree burns to was transferred to 3 The local Hospital I dated 11/19/11 doc history with diagnos Pulmonary Disease Retardation and Sc documents R1 had area and upper lip area, broken blister quarters of noses passagesbroken appearance and ins upper lip consisten burndeep swelling report documented scope of the airway Throat) physician. "Complex Facial Bu Thickness Upper L Burns to the right ir and left index finge Injury."	esident to (local hospital) via (19/11 9:00 pm documented ator and was being transferred a hospital nurse reported the ated, and put on ventilator for in naso/oral pharynx, R1 had and degree facial burns and or right hand. The resident a Springfield burn unit. Emergency Room Report cuments R1's past medical ses of Chronic Obstructive e, Hypertension, Mental chizophrenia. The report burns to mid face and nose with soot noted diffusely to rs over nose tip to about three oot and singed burns to nasal blisters to upper lip, pale in sensitive to touch to entire t with possible full thickness g in nasal passages". The R1 had a nasopharyngeal y by (Z2) ENT (Ear Nose The report documented there about the tracheal level " The as protected with intubation as given medication for pain . The clinical impression was urns with Suspected Full ip Burn. Partial Thickness ndex, third and fourth finger r and Suspected Inhalation	F 32	23		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С B. WING 145636 11/30/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **716 EIGHTEENTH STREET CHARLESTON REHAB & HEALTH CARE CENTER** CHARLESTON, IL 61920 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 323 Continued From page 3 F 323 escorted resident to smoking area. E7 did not have nurse remove oxygen before exiting facility. Resident attempted to relight cigarette and ash caused flash burn." The report documented the resident was assessed and sent to (local hospital) and then was transferred to a Springfield hospital. The report documented "During interviews it was determined (E7) was aware oxygen was to be removed prior to resident smoking and this did not occur. Resident is alert and oriented." Administrator. E1 stated on 11/28/11 at 10:10 am that R1 was still in the Burn Unit of the hospital. E1 confirmed that R1 had gotten burned on 11/19/11 while out in the courtyard smoking. E1 stated that other residents outside at the time of the incident included R2 and R3 who she stated were non interviewable. E1 during the same interview, all of the resident smoking is done outside of the building, and is supervised by staff with a smoking schedule. The residents are taken outside to the outdoor courtyard to smoke. E1 demonstrated that the courtyard was located between the West and Northwest wings of the facility. A side walk from each wing leads to a covered gazebo in the center of of the courtyard approximately 25 feet from the building. The exterior doors to the courtyard on the West and Northwest wings were equipped with a keyed alarmed lock. E1 stated that the staff had to use a key to shut off the alarm and open the door before letting residents outside to smoke. A large sign was taped to the door which said **"NO OXYGEN BEYOND THIS POINT NURSING** MUST REMOVE OXYGEN". On 11-28-11 at 10:20 a.m. E1 stated that this sign had been

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CENTER STATEMENT	RS FOR MEDICARE	AND HUMAN SERVICES	(X2) N	IULT	IPLE CONSTRUCTION	FORM OMB NO. (X3) DATE SU	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BU	LDIN	IG	COMPLE	
		145636	B. WI	NG _			C 0/2011
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
CHARLE	STON REHAB & HEA	LTH CARE CENTER			716 EIGHTEENTH STREET CHARLESTON, IL 61920		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	Continued From pa posted on both doo The Smoking Sche the exterior doors to schedules listed sm from 6:30 am until 8 Housekeeping staff staff were assigned smoke times excep a Certified Nurse A smoking. The sign ONLY permitted du times. ALL resident for staff to assist th allowed one cigared E1 provided E7's w 11/20/11 (error on of took (R1, R4, R3, a was smoking and h because he took a just sparked and we the flames out and the closest CNA to time he was attemp cigarette". On 11-28-11 at 10: interviewed E7 and removed R1's oxyg out to smoke. E1 st aware of the policy	nge 4 prise after R1's accident. dule was posted on the wall by the courtyard. The noking times every two hours 8:30 pm. Laundry staff, f, Social Services, or Dietary 4 to supervise smoking for all to 4:00 pm and 8:30 pm when ide (CNA) supervises the stated "Resident smoking is uring the above designated ts must be at the door waiting em outside. Residents are the per smoke break." written statement dated date) 6:31 pm which stated "I and R2) out to smoke. (R1) is oxygen tubes caught on fire drag off of his cigarette and it ent up in flames. I tried to get off his tubes and then Itold go find her (nurse)At the oting to relight his own 10 a.m. E1 stated that she had asked why she had not gen tank before she took him tated E7 stated that she was (oxygen safety) but was "busy ngs." E1 stated that's why E7's		, 323	DEFICIENCY)		
	she was the nurse	n 11/28/11 at 11:00 am that on call and was notified by had been injured. E3 stated					

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С B. WING 145636 11/30/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **716 EIGHTEENTH STREET CHARLESTON REHAB & HEALTH CARE CENTER** CHARLESTON, IL 61920 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 323 Continued From page 5 F 323 when she arrived at the facility about five minutes later, R1 was at the the nurse's station in his wheelchair with an ice pack on his face and mouth. E3 stated she interviewed Laundry staff E7, who was the assigned smoking monitor. E7 kept saving that the nurse had not taken off the oxygen. E3 stated she told E7 "But you were the one who lit the cigarette". E3 said she did confirm that E7 had taken the residents out to the courtyard to smoke, that R1 was wearing the oxygen when E7 took him out to smoke and that E7 had lit R1's cigarette. E3 stated the Smoking Protocol was the nurse keeps the cigarettes at the nurse's station. The Nurse hands out the cigarettes when the assigned staff member is ready to take out the resident to smoke. According to E3 the nurse is to remove any oxygen from the resident before the resident is taken out to smoke. E3 stated on 11/29/11 at 11:00 am when she arrived at the facility R1 was inside the facility and the oxygen tank was outside in the courtyard, and the oxygen tubing was all burnt. R2 stated on 11/28/11 at 12:15 pm that she was present when R1 had been burned. R2 stated the laundry girl, E7 had taken her, R3, R4 and R1 out to the courtyard, the nurse wasn't at the desk at the time around 6:15 pm. R2 said E7 had the cigarettes and they were all sitting pretty close together around a round metal table in the gazebo. R2 stated she was across the table from R1 and R3 was seated right next to R1. R2 stated E7 had lit our cigarettes, and (R1's) cigarette hadn't lit all the way, he took a drag and

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: IL6001358

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY TED
		145636	B. WI	NG			C D/ 2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CHARLE	STON REHAB & HEA	LTH CARE CENTER			16 EIGHTEENTH STREET CHARLESTON, IL 61920		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323		-	F	323			
	yelled and started s told (E7) someone	ght the tubing on fire. R1 slapping his face. R2 stated " I needed to get a nurse!" E7 West Wing nurse and they nk off of him.					
	lighting up a cigared He was sitting right didn't get burned." I he felt the heat on h he has smoked with	45pm R3 stated "He (R1) was tte when it kind of flared up. next to me. I felt the heat but I R3 said he saw the blaze and his wrist and face. R3 stated h "that guy" before and "they k and everything off before but					
	present when R1 g a cigarette and whe burned. R4 said his the hospital. R4 sta	D pm. R4 confirmed he was ot hurt. R4 stated that R1 had en he lit the cigarette, he got s face was burned and he's in ted that they don't carry their cort lights the cigarette.					
	11/19/11 she was to Wing. E11 stated s when she was notif been burned while E12, the other nurs was with R1. E11 s from nose to chin, H consciousness and face and his hand.	on 11/28/11 at 2:00 pm that on he Nurse for the Northwest she had been in a patient room ied by CNA E8 that R1 had smoking outside with oxygen. e had already responded and said R1's face was blackened he had a good level of was complaining of pain to E11 stated R1's physician had I times with no response and d.					
	residents R1, R2, F	e was not present when the R3 and R4 were taken out to anded R3 and R4 their					

STATEMEN	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		(X3) DATE S COMPL	
		145636	B. WING	·	11/3	30/2011
	ROVIDER OR SUPPLIER	ALTH CARE CENTER	s	TREET ADDRESS, CITY, STATE, ZIP CODE 716 EIGHTEENTH STREET CHARLESTON, IL 61920		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE
F 323	cigarettes, which w cart after supper w to smoke. E11 sta cigarettes as he wa at the desk. E11 s cigarettes and the filters are kept in th Nurse Aide) room. mini portable liquid there when the res smoke, she would (tank and cannula) they went outside. Nurse, E10 stated had been in the dir supper when CNA there was an emer hand blown up in F had taken resident removed the oxyge courtyard to assess conscious, the staf tank and the cannu was black. E10 sta after 6:00 pm. E10 and she went insid don't take the resio residents have oxy oxygen tank off be E10 stated on 11/2 R1 in the courtyard asked her what to told them to get it a E10 didn't recall if t residents chair, E1	Age 7 vere locked in her medication thile they were waiting to go out ted she did not give R1 any as in the hall by his room, not tated R1 hand rolls his machine and tobacco and he unlocked CNA (Certified E11stated that R1 utilizes a loxygen tank. If she had been idents were taken out to have removed the whole thing from the wheelchair before on 11/28/11, at 2:10 pm she hing room on 11/19/11 after E8 had come to her saying gency, that the oxygen tank R1's face, that the laundry girl s out to smoke and had not en tank. E10 went out to the s R1. E10 stated R1 was if had turned off the oxygen ula was burnt and R1's face ted it was dark outside it was the other nurse then took over e to call. E10 stated Nurses dents outside to smoke. If the gen the nurse it to take the fore they go outside. 29/11 at 2:30 pm when she saw d (on 11/19/11) the staff had do with R1's oxygen tank, E10 away from him and the chair. the tank was still on the 0 stated the oxygen cannula here was a piece of stuck to	F 32			

		I AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU			(X3) DATE SU COMPLE	
		145636	B. WI	NG _			C 0/2011
NAME OF P	ROVIDER OR SUPPLIER		I	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
CHARLE	STON REHAB & HEA	LTH CARE CENTER			716 EIGHTEENTH STREET CHARLESTON, IL 61920		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323	Continued From pa	ge 8	F	323	3		
	had brought R1 bac supper on 11/19/11 the residents out to putting people to be him what happened smoking and there tubing was on fire s R1. E7 stated he s stated he grabbed to rushed outside.	11/28/11 at 4:15 pm that he ck to the North West wing after . E8 said laundry staff takes smoke while the CNA's are ed. E8 stated that E7 had told d, she said that R1 was was a poof and the plastic so she pulled the tubing off of hut the oxygen tank off . E7 the nurse (E10) and they					
	outlined conducting assessment for res Smoking Contract of Service Designee a follow for smoking. safety concerns for that smoke in the p E4 stated on 11/28, not have a smoking contract completed Plan that only state cannula), Smokes", any safety informati tank before smokin At the bottom of the "11/19/11 Sent to E for safety upon read safety."	 y "Safe Smoking Policy" a smoking safety risk idents that smoke, having a completed by the Social and resident and listed rules to There was no discussion of residents who utilize oxygen olicy. Care Plan Coordinator, /11 at 11:00 am that R1 did g assessment or smoking R1 only had an Interim Care d "O2 (oxygen) per N/C (nasal E4 stated she didn't include ion for removing the oxygen g because it was facility policy. a page E4 had written R for eval and tx, will re-eval dmit. All inservice on O2 					
	states "Safety stand to ensure the safety transport, storage a	n Safety General Standards" dards for oxygen are designed y of all persons involved in the and use of oxygen. Oxygen is jas. In the presence of an					

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		AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENT AND PLAN OF CORRECTIO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		145636	B. WI	NG _			C 0/2011
NAME OF PROVIDER OR S	SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CHARLESTON REHA	AB & HEA	LTH CARE CENTER			716 EIGHTEENTH STREET CHARLESTON, IL 61920		
PREFIX (EACH D	DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
accelerate Smoking: 3 where oxys Residents, and familie use of oxys hazards ar On 11-28- notified that identified. 11/19/11 w oxygen wa surveyor c and record following a Jeopardy: On 11/19/7 removed of assessed a Treatment On 11/19/7 on Oxygen are inservi starting the Signs were designated oxygen pri On 11/19/7	urce and combus Smoking gen is sto nursing es must b gen. The nd all reg 11 the fa- at an Imm The Imm when E7 f as remove onfirmed I review t inctions to 11 Staff r bxygen, m and sent 11 The fa- n Safety w ced. Sta eir sched e posted d smoking or to exit 11 1:1 (or afety was d are on of 11 the Qu	a fuel oxygen will vigorously tion." The policy states "A. No is prohibited in all areas ored, transported, or used F. agency personnel/caregivers be educated regarding the safe ey must be informed of the julations associated with use." cility Administrator, E1 was nediate Jeopardy had been nediate Jeopardy began on failed to ensure that R1's ed before smoking. The though interview, observation, that the facility took the remove the Immediate member extinguished flames, noved resident to safety, R1 out for Emergency Medical acility initiated all staff inservice which is on going until all staff aff are being inserviced prior to uled shift. on doors leading to the g area to have nurse remove ing.	F	323			

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	.DING		COMPLE	
		145636	B. WIN	G			C
	ROVIDER OR SUPPLIER	140000		OTDEET	ADDRESS, CITY, STATE, ZIP CODE	11/3	0/2011
		ALTH CARE CENTER		716 E	RLESTON, IL 61920		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 323	Continued From pa facility which was o	age 10 conducted by Administrator E1.	F 3	23			
F9999		smoking policy was reviewed ude precautions for residents	500	00			
F9999	LICENSURE VIO		F99	99			
	300.610a) 300.1210b) 300.1210d)6) 300.3240a)						
	Section 300.610 R	esident Care Policies					
	procedures, govern the facility which sl Resident Care Pol- least the administr the medical adviso representatives of the facility. These with the Act and al These written polic operating the facili- least annually by th	have written policies and ning all services provided by hall be formulated by a icy Committee consisting of at ator, the advisory physician or ory committee and nursing and other services in policies shall be in compliance I rules promulgated thereunder. cies shall be followed in ty and shall be reviewed at his committee, as evidenced by d dated minutes of such a					
	Section 300.1210 Nursing and Perso	General Requirements for nal Care					
	and services to att practicable physica	provide the necessary care ain or maintain the highest al, mental, and psychological esident, in accordance with					

		HAND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
		145636	B. WI	NG			C 0/2011
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>			REET ADDRESS, CITY, STATE, ZIP CODE		
CHARLE	ESTON REHAB & HEA				716 EIGHTEENTH STREET CHARLESTON, IL 61920		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	each resident's com plan. Adequate and care and personal of resident to meet the care needs of the re- d) Pursuant to subs care shall include, a and shall be practic seven-day-a-week f 6) All necessary pre- assure that the resi as free of accident in nursing personnel si that each resident r and assistance to p Section 300.3240 A a) An owner, licensi- agent of a facility sh resident. These regulations a the following: Based on observati interview the facility oxygen tank, and ca allowing R1 to smol oxygen cannula ign burns to R1's face, residents present (fi injury. R1, R2, R3, a	nprehensive resident care d properly supervised nursing care shall be provided to each e total nursing and personal esident. section (a), general nursing at a minimum, the following ced on a 24-hour, basis: ecautions shall be taken to idents' environment remains hazards as possible. All shall evaluate residents to see receives adequate supervision prevent accidents.	F9	999			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMEN	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU			(X3) DATE SU COMPLE	JRVEY TED
		145636	B. WI	NG _			C D/2011
	ROVIDER OR SUPPLIER	LTH CARE CENTER			TREET ADDRESS, CITY, STATE, ZIP CODE 716 EIGHTEENTH STREET CHARLESTON, IL 61920	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	On 11/10/11 the fac report to the State S Agency Regional O outside to smoke w causing a flash burn Investigation initiate The Admission reco the facility on 11/08 Service History and that R1 was 64 yea his apartment in the "resident says he m to come (to the faci trouble breathing an R1's admitting diag Physicians Order S obstructive pulmona R1 had 11/08/11 or Occupational theral admitting physician per minute by nasa R1's assessment do was cognitively inta of one staff for trans- independent in whe assessment docum expected to be disc the careplan team h feasible for R1. R1's Nurses notes of document "Nurse of acquired facial burr O2 (oxygen) tank.	ge 12 cility faxed an initial incident Survey and Certification ffice which stated "Resident ith oxygen on, cigarette lit n November 19, 2011. ed and final report to follow." ord shows R1 was admitted to /11 for a short stay. Social Admission note documented rs old and was admitted from e community. Notes document eeds nursing care and wants lity) to get better. Resident has nd gets winded easily." nosis on the November 2011 heet was COPDE (chronic ary disease excacerbation). ders for Physical and py for 30 days. R1 had an s order for Oxygen at 2 liters I cannula PRN (as needed). ated 11/21/11 documented R1 ct, required limited assistance sfers and ambulation, and was belchair mobility. The tented goal was resident tharged to the community and nad also deemed discharge	F9	999	9		

STATEMEN	T OF DEFICIENCIES DF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	JLTIPLE CONSTRUCTION	(X3) DATE S COMPL	
	DI CORRECTION	IDENTIFICATION NOMBER.	A. BUIL		COMPL	C
		145636	B. WIN	G	11/3	30/2011
	PROVIDER OR SUPPLIER	ALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 716 EIGHTEENTH STREET CHARLESTON, IL 61920	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETIO DATE
F9999	911." Notes of 11 R1 was on a ventili- via helicopter. The resident was intuba- soot accumulation acquired 2nd and 3 2nd degree burns in was transferred to The local Hospital dated 11/19/11 dot history with diagno Pulmonary Disease Retardation and Sc documents R1 had area and upper lip area, broken bliste quarters of noses passagesbroken appearance and in upper lip consistent burndeep swelling report documented scope of the airway Throat) physician. was "some edema resident's airway w and the resident w relief and sedation "Complex Facial B Thickness Upper L Burns to the right in and left index finge Injury."	age 13 /19/11 9:00 pm documented ator and was being transferred e hospital nurse reported the ated, and put on ventilator for in naso/oral pharynx. R1 had Brd degree facial burns and to right hand. The resident a Springfield burn unit. Emergency Room Report cuments R1's past medical ses of Chronic Obstructive e, Hypertension, Mental chizophrenia. The report d burns to mid face and nose with soot noted diffusely to rs over nose tip to about three oot and singed burns to nasal blisters to upper lip, pale in sensitive to touch to entire t with possible full thickness g in nasal passages." The d R1 had a nasopharyngeal y by (Z2) ENT (Ear Nose The report documented there about the tracheal level." The vas protected with intubation as given medication for pain . The clinical impression was urns with Suspected Full .ip Burn. Partial Thickness ndex, third and fourth finger er and Suspected Inhalation	F99	99		

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С B. WING 145636 11/30/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **716 EIGHTEENTH STREET CHARLESTON REHAB & HEALTH CARE CENTER** CHARLESTON, IL 61920 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F9999 Continued From page 14 F9999 have nurse remove oxygen before exiting facility. Resident attempted to relight cigarette and ash caused flash burn." The report documented the resident was assessed and sent to (local hospital) and then was transferred to a Springfield hospital. The report documented "During interviews it was determined (E7) was aware oxygen was to be removed prior to resident smoking and this did not occur. Resident is alert and oriented." Administrator, E1 stated on 11/28/11 at 10:10 am that R1 was still in the Burn Unit of the hospital. E1 confirmed that R1 had gotten burned on 11/19/11 while out in the courtyard smoking. E1 stated that other residents outside at the time of the incident included R2 and R3 who she stated were non-interviewable. E1 stated during the same interview that all of the resident smoking is done outside of the building, and is supervised by staff with a smoking schedule. The residents are taken outside to the outdoor courtyard to smoke. E1 demonstrated that the courtyard was located between the West and Northwest wings of the facility. A sidewalk from each wing leads to a covered gazebo in the center of of the courtyard approximately 25 feet from the building. The exterior doors to the courtyard on the West and Northwest wings were equipped with a keyed alarmed lock. E1 stated that the staff had to use a key to shut off the alarm and open the door before letting residents outside to smoke. A large sign was taped to the door which said **"NO OXYGEN BEYOND THIS POINT NURSING** MUST REMOVE OXYGEN." On 11-28-11 at 10:20 a.m. E1 stated that this sign had been

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

		I AND HUMAN SERVICES			FORM	APPROVED	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N	IULTI	PLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	F CORRECTION	IDENTIFICATION NOMBER.	A. BU	LDIN	G		
		145636	B. WI	NG		11/30/2011	
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CHARLE	STON REHAB & HEA	LTH CARE CENTER			16 EIGHTEENTH STREET CHARLESTON, IL 61920		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACT TAG CROSS-REFERENCED TO T DEFICIENC		ULD BE	(X5) COMPLETION DATE
F9999	•	ge 15 rs after R1's accident. dule was posted on the wall by	F99	999			
	the exterior doors to schedules listed sm from 6:30 am until 8 Housekeeping staff staff were assigned smoke times excep a Certified Nurse Ai smoking. The sign ONLY permitted du times. ALL resident for staff to assist the allowed one cigaret	b the courtyard. The hoking times every two hours 3:30 pm. Laundry staff, 5, Social Services, or Dietary 1 to supervise smoking for all bt 4:00 pm and 8:30 pm when ide (CNA) supervises the stated "Resident smoking is ring the above designated as must be at the door waiting em outside. Residents are the per smoke break."					
	11/20/11 (error on of took (R1, R4, R3, a was smoking and h because he took a just sparked and we the flames out and the closest CNA to	ritten statement dated date) 6:31 pm which stated "I nd R2) out to smoke. (R1) is oxygen tubes caught on fire drag off of his cigarette and it ent up in flames. I tried to get off his tubes and then Itold go find her (nurse)At the oting to relight his own				OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED C 11/30/2011	
	interviewed E7 and removed R1's oxyg out to smoke. E1 st aware of the policy	10 a.m. E1 stated that she had asked why she had not en tank before she took him tated E7 stated that she was (oxygen safety) but was "busy ngs." E1 stated that's why E7's erminated.					
	she was the nurse of	n 11/28/11 at 11:00 am that on call and was notified by had been injured. E3 stated					

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С B. WING 145636 11/30/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **716 EIGHTEENTH STREET CHARLESTON REHAB & HEALTH CARE CENTER** CHARLESTON, IL 61920 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F9999 Continued From page 16 F9999 when she arrived at the facility about five minutes later, R1 was at the the nurse's station in his wheelchair with an ice pack on his face and mouth. E3 stated she interviewed Laundry staff E7, who was the assigned smoking monitor. E7 kept saving that the nurse had not taken off the oxygen. E3 stated she told E7 "But you were the one who lit the cigarette." E3 said she did confirm that E7 had taken the residents out to the courtyard to smoke, that R1 was wearing the oxygen when E7 took him out to smoke and that E7 had lit R1's cigarette. E3 stated the Smoking Protocol was the nurse keeps the cigarettes at the nurse's station. The nurse hands out the cigarettes when the assigned staff member is ready to take out the resident to smoke. According to E3 the nurse is to remove any oxygen from the resident before the resident is taken out to smoke. E3 stated on 11/29/11 at 11:00 am when she arrived at the facility R1 was inside the facility and the oxygen tank was outside in the courtyard, and the oxygen tubing was all burnt. R2 stated on 11/28/11 at 12:15 pm that she was present when R1 had been burned. R2 stated the laundry girl, E7 had taken her, R3, R4 and R1 out to the courtyard, and the nurse was not at the desk at the time around 6:15 pm. R2 said E7 had the cigarettes and they were all sitting pretty close together around a round metal table in the gazebo. R2 stated she was across the table from R1 and R3 was seated right next to R1. R2 stated E7 had lit our cigarettes, and (R1's)

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		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391	
STATEMENT OF DEFICIENCI AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	TED	
145636			B. WI	NG _		C 11/30/2011		
NAME OF PROVIDER OR SL		LTH CARE CENTER			TREET ADDRESS, CITY, STATE, ZIP CODE 716 EIGHTEENTH STREET CHARLESTON, IL 61920			
PREFIX (EACH DE	FICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
and it spark yelled and s told (E7) so said a CNA took the oxy On 11/28/11 lighting up a He was sitti didn't get bu he felt the h he has smo always took this time the On 11/28/11 present whe a cigarette a burned. R4 the hospital own lighters Nurse, E11 11/19/11 sh Wing. E11 when she w been burnet E12, the oth was with R1 from nose to consciousno face and his been paged 911 was the	d not lit ed, and started s meone got the /gen tar 1 at 12:4 a cigare ng right urned." I eat on I ked with the tan ey didn't 1 at 1:30 en R1 g and whe said hi . R4 sta s tated of e was t stated of e was t stated of e was t stated of e an or stated of a chin, I ess and s hand. I severa en calleo	all the way. He took a drag caught the tubing on fire. R1 slapping his face. R2 stated "I needed to get a nurse!" E7 West Wing nurse and they hk off of him. 45pm R3 stated "He (R1) was the when it kind of flared up. next to me. I felt the heat but I R3 said he saw the blaze and his wrist and face. R3 stated h "that guy" before and "they k and everything off before but ." 0 pm. R4 confirmed he was ot hurt. R4 stated that R1 had en he lit the cigarette, he got s face was burned and he is in ted that they do not carry their cort lights the cigarette. 0 11/28/11 at 2:00 pm that on he nurse for the Northwest she had been in a patient room ied by CNA E8 that R1 had smoking outside with oxygen. e had already responded and said R1's face was blackened he had a good level of was complaining of pain to E11 stated R1's physician had I times with no response and	F9	999	9			

DEPAR CENTE	PRINTED: 02/22/2012 FORM APPROVED OMB NO. 0938-0391						
STATEMENT OF DEFICIENCIES (X1) PROVID		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
145636		B. WI	NG _		C 11/30/2011		
NAME OF PROVIDER OR SUPPLIER CHARLESTON REHAB & HEALTH CARE CENTER				7	REET ADDRESS, CITY, STATE, ZIP CODE 716 EIGHTEENTH STREET CHARLESTON, IL 61920		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREF TAC		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	(4) ID SUMMARY STATEMENT OF DEFICIENCIES REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL FAG REGULATORY OR LSC IDENTIFYING INFORMATION)		F9	999			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145636	B. WI	NG _		C 11/30/2011	
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CHARLE	STON REHAB & HEA	LTH CARE CENTER			716 EIGHTEENTH STREET CHARLESTON, IL 61920		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	face. CNA, E8 stated on had brought R1 bac supper on 11/19/11 the residents out to putting people to be him what happened smoking and there tubing was on fire s R1. E7 stated he s stated he grabbed to rushed outside. The undated facility outlined conducting assessment for res Smoking Contract of Service Designee a follow for smoking. safety concerns for that smoke in the p E4 stated on 11/28/ not have a smoking contract completed Plan that only state cannula), Smokes.' any safety informati tank before smokin At the bottom of the "11/19/11 Sent to E for safety." The facility "Oxyger	ge 19 here was a piece stuck to R1's 11/28/11 at 4:15 pm that he ck to the North West wing after . E8 said laundry staff takes smoke while the CNA's are ed. E8 stated that E7 had told d. She said that R1 was was a poof and the plastic o she pulled the tubing off of hut the oxygen tank off. E7 the nurse (E10) and they "Safe Smoking Policy" a smoking safety risk idents that smoke, having a completed by the Social and resident, and listed rules to There was no discussion of residents who utilize oxygen olicy. Care Plan Coordinator, '11 at 11:00 am that R1 did assessment or smoking . R1 only had an Interim Care d "O2 (oxygen) per N/C (nasal ' E4 stated she did not include ion for removing the oxygen g because it was facility policy. e page E4 had written R for eval and tx, will re-eval dmit. All inservice on O2	F9	9999			
		dards for oxygen are designed of all persons involved in the					

		I AND HUMAN SERVICES				FORM	02/22/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
145636		B. WI	NG		C 11/30/2011		
NAME OF PROVIDER OR SUPPLIER CHARLESTON REHAB & HEALTH CARE CENTER			·		TREET ADDRESS, CITY, STATE, ZIP CODE 716 EIGHTEENTH STREET CHARLESTON, IL 61920		
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F9999	a non -flammable g ignition source and accelerate combus Smoking: Smoking where oxygen is sto Residents, nursing and families must b use of oxygen. The	Ige 20 and use of oxygen. Oxygen is as. In the presence of an a fuel oxygen will vigorously tion." The policy states "A. No is prohibited in all areas ored, transported, or used F. agency personnel/caregivers be educated regarding the safe y must be informed of the ulations associated with use." (A)	F9	999	9		

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