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	IL6005714	A. BUILDING: _____ B. WING _____	C 12/11/2014

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ALDEN LONG GROVE REHAB &HC CTR	2308 OLD HICKS ROAD LONG GROVE, IL 60047

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S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall 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 resident care plan. 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.	S9999		

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d) Pursuant to subsection (a), 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 300.1220 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 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.

Section 300.3240 Abuse and Neglect

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S9999	Continued From page 2 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) These Requirements are not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to supervise and monitor resident smoking, failed to accurately assess resident smoking risks and failed to develop a care plan with safe smoking interventions. This failure resulted in R4 sustaining facial burns from smoking unsupervised with Oxygen in use. This applies to one resident (R4) from a sample of ten reviewed for smoking (R5, R6, R7, R9, R10, R11, R12, R13 and R14) from a total sample of 15. While the Immediate Jeopardy was removed on 12-9-14 at 11:20am, the facility remains out of compliance at a level 2 due to the need to evaluate the effectiveness of corrective measures put in place, the need to complete the in-servicing plan, and to monitor and evaluate the effectiveness of the smoking program. The findings include: R4 is a 66 year old male resident with impaired right sided movement who is coded a 3/2 (extensive one person assistance) for dressing and transfer per the MDS (Minimum Data Set) Assessment dated 10-17-14. R4 is unable to move the right side of his body. R4 uses 02	S9999		

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(Oxygen) at 2-3 liters per portable tank. R4 is also coded as having a 7 score for his BIMS (Brief Interview for Mental Status) indicating that R4 is cognitively impaired. R4 also needs extensive assistance to move in and out of the wheel chair.

The facility's incident report dated 11/30/2014 showed R4 went to one of the facility's patios and started smoking around 11:30 a.m., but did not remove the nasal cannula with oxygen as he usually does. There was a short burst of flames around his nose. R4 received burns to his face. The physician was contacted and R4 was transported to the hospital at 11:55 a.m.

On 11-30-14 about 11:30am, R4 was smoking in the outdoor patio with his 02 running. According to another resident present (R6) there was a pop and a spark and R4 ' s face and beard was on fire. R6 attempted to put the fire out with his bare hands and then R6 ran to get staff inside the building. R6 then saw E7 (Nurse Aid) in the hall way and was able to bring E7 to the outdoor patio to R4. E7 then ran to get help and E5 (Registered Nurse) responded and provided basic first aid and the physician was called and R4 was sent to the local hospital emergency room.

Hospital records dated 11/30/2014 showed R4 sustained burns to a 2 centimeter (cm.) area next to his right nare. The burn extended across R4's nose and to a small, 1 cm. area in diameter above the left lip. There was scorching to both nares (nostrils) with soot at bilateral nares openings. R4 was discharged back to the facility with orders to treat the burned areas with Silvadene ointment twice a day and pain medication every 4 hours as needed. A follow up

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appointment was also to be scheduled within 3 to 5 days at a burn clinic.

E7 (Nurse Aid) stated during interview on 12-4-14 at 10:25am, that she responded to R4 from inside the building. She was on break and saw that R4 was burnt with black soot on his face. The 02 tubing was separated into two pieces.

E5 (Registered Nurse) also responded and noted the burns. The physician was called and the resident was sent for treatment to the local ER. The resident has since received additional treatment at the burn center at Loyola Hospital.

R6 was interviewed on 12-4-14 about R4 ' s incident. R6 said that he was with R4 and other residents smoking then R6 heard a pop like a plane. R6 said R4's face was on fire. R6 tried to smother the flame on R4's face using his hands. R6 added it was like a flash. R6 left the patio and ran for help inside the facility. "I saw E7 CNA (Certified Nursing Assistant) in the hallway." R6 was able to bring E7 to the patio to care for R4. R6 was also asked about the facility's smoking schedule. R6 said that he does not pay attention to the schedule. R6 stated the residents smoke whenever they want. R6 said he keeps his own cigarettes and the lighter in his room.

On 12/04/2014 at 9:35 a.m., E5 (RN - Registered Nurse) said R4 had cigarettes in his room the day of the incident, and that perhaps they were brought to him by a family member. In a separate interview on the same day at 4:02 p.m., E5 said R4 did not come to him to request his oxygen tank be turned to off before he visited the smoking area, as he had done in the past. E5 said R4 typically asked a nurse to turn his oxygen tank to off, and then the nurse would remove his

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nasal cannula, drape it over the wheelchair handle, and R4 would proceed out to the smoking patio with the oxygen tank and tubing attached to his wheelchair.

On 12/04/2014 at 2:50 p.m., E1 (Administrator) stated that residents who smoke can smoke whenever they want. E1 said that there were set smoking times when the atrium patio was used as the smoking area, but that was to ensure that the doors were not opened during meal times, as the atrium patio was adjacent to the dining room. Since the smoking area was moved to the patio off of the hallway where the incident occured, set smoking times and supervision stopped. E1 stated that smoking assessments are done for all residents who smoke.

A review of the facility ' s smoking assessment indicates that resident physical mobility issues and other physical impairments are not included in the assessments. R4 was assessed to be a " safe " smoker on the assessment completed 7-18-14; however, R4 has severe mobility issues as well as cognitive issues. The use of Oxygen was not addressed as a risk factor. R4 ' s care plan dated 10-26-11 indicates that R4 is a " safe smoker " and is allowed his own cigarettes and no restrictions regarding smoking. The care plan did not address R4 ' s BIMS score, mobility issues, and use of Oxygen.

A review of the facility ' s policy entitled, " Smoking Assessment and Safety Protocol " revised May of 2014 shows, " Oxygen use is prohibited in smoking areas for the safety of all parties. "

On 12/04/2014 at 2:30 p.m., E3 (Director of Nursing) stated that when R4 wanted to go to the

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patio to smoke, he would obtain his cigarettes from the nurse. E3 said that R4 would remove his nasal cannula from his face and loop the tubing over the back of his wheelchair. The nurse would then turn off the oxygen tank, but would leave the tank attached to the back of R4's wheelchair while he went out to the patio to smoke. E3 stated that staff members do not monitor the smoking patio. E3 stated that R4 did have his oxygen on when he went to smoke on 11/30/2014. She said that she was unaware if there were any other times that R4 would go to the patio to smoke while his oxygen was in use and the oxygen tank was in the on position. E3 also said that she was unsure how often R4 would go out to smoke each day but thought that it might be three times a day. E3 stated that she did not witness the burn to R4's face because she was not present at the time. E3 said that based on the report from the nurse who was present, R4 had peeling skin immediately after the incident, and she would think that the burns were second degree burns.

Z2 (Owner of Oxygen Supply Company) was interviewed on 12-4-14 at 3:30pm and stated that no flames or smoking should be in the same area as Oxygen, even if the tank is outdoors.

R4 followed up at the burn clinic on 12/4/2014. The burn clinic progress note dated 12/4/2014 showed both nares were "raw with debris occluding the opening, partial thickness burn to nose; upper lip pink with open, crusted area."

In both hospital records it is noted that R4 was smoking with 02 running.

During a telephone interview on 12/4/2014 at 4:00 p.m., Z3 (Advanced Practice Nurse - burn clinic) said all of R4's facial burns were 2nd degree

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burns, all of the nasal mucosa hair is gone, and the "nares look pretty bad." Z3 said it was too early to say if R4 will have permanent scarring from the burns.

On 12/04/14 at 9:30 a.m., R6, R9, and R10 were observed on the patio smoking. There was no staff supervision of the residents while they were smoking.

At 9:45 a.m., R6 was again observed on the patio, smoking by himself. There was no staff supervising the smoking area.

On 12/04/2014 at 9:15 a.m. R5 stated that he is a smoker and that he is allowed to keep his own cigarettes in his room. R5 said that prior to this week he had seen R4 out on the smoking patio with oxygen tubing on his nares. He stated that he was not on the patio at the time of the incident. R5 also said that he had not seen any staff members on the patio unless they were out there to smoke themselves. R5 is cognitively intact per his BIMS dated 9-25-14.

According to the BIMS assessment dated 10/31/2014, R7 was cognitively intact. On 12/04/2014 at 9:55 a.m. R7 stated that she is a smoker and uses the patio for smoking. R7 stated that there were never any staff members out on the patio while she was out there. R7 stated that prior to this week she has seen R4 out on the patio smoking while he had the oxygen nasal cannula in place on his face. R7 said that she was unaware if the oxygen was turned on during that time but said the tubing was definitely on his face. She stated that she would have said something if she would have known the oxygen was on. R7 denied that she was on the patio during the incident with R4. On 12/04/2014 at

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11:00 a.m. R7 stated that there is no schedule for smoking that she is aware of. She said that the facility was relaxed about that and residents can go out to the patio to smoke anytime they want.

On 12/04/2014 at 10:25 a.m. R8 stated that she was not a smoker but was aware that the residents that smoke will go in and out of the patio whenever they want and that staff members are not present on the patio. According to the BIMS assessment dated 10/28/2014, R8 was cognitively intact.

On 12/04/2014 a sign was posted on R4 ' s closet door indicating 5 different smoking times between the hours of 8:30 a.m. and 7:15 p.m. The various times also indicated which staff would be supervising the smoking area. This schedule was dated 10/22/2013.

On 12/04/2014 at 11:18 a.m., E11 (Activity Director) said the schedule posted in R4 ' s room was an old schedule that was not in use anymore. E11 said the old schedule was used when residents smoked in the atrium patio adjacent to the dining room. E11 said the schedule was used to guarantee smoking did not interfere with meal times, as residents frequently complained about the smoke and outside air coming into the dining room during mealtimes. E11 said since the smoking area was moved to a different patio, the schedule and supervision stopped, and she believed this happened several months ago. E11 also stated she is aware that residents share cigarettes with each other.

On 12/4/2014 at 11:10 a.m., E9 and E10 (Activity Assistants) said " We stopped watching the residents smoke when they moved the smoking area. Someone from administration said we don '

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S9999	Continued From page 9 t have to follow the schedule anymore. " (A)	S9999		

Imposed Plan of Correction for Alden Long Grove Rehab & HC CTR

F 323 Plan of Correction

Submission of this Plan of Correction by Alden Long Grove is not a legal admission that a deficiency exists or that this Statement of Deficiencies was correctly cited. In addition, preparation and submission of this POC does not constitute an admission or agreement of any kind by the facility of the truth of any facts set forth in this allegation by the survey agency.

1. The facility has taken the following action identified on the CMS-2567:
   - R4 has quit smoking on the day of the incident, November 30, 2014.
   - Smoking assessments were completed on all residents that smoke and care plans were updated as appropriate
   - NHA or designee identified all current smokers at the facility
   - Staff were in-serviced regarding smoking policy and protocol, smoking times, as well as prohibiting oxygen use while resident is smoking
   - All residents who smoke were educated on the smoking policy and protocol, smoking times and has signed the smoking agreement
   - A schedule has been created with designated smoking times which will be supervised by a staff member
   - Smoking Apron is used for those with mobility limitations
   - Smoking policy was revised to include monitoring during smoking times
   - Family and Friends were educated on the smoking policy via posting at the front lobby of the facility.

2. Actions taken to identify other residents that have the potential to be affected and will not reoccur.
   - No other residents affected

3. The measures the facility will take to ensure that proper practices continue:
   - Completion of the Resident Smoking agreement upon admission into the facility
   - On-going education regarding smoking policy and protocol will be provided on admission for new residents, family and friends
   - On-going in-service of staff member regarding smoking policy and protocol
   - QA/QI tool was initiated by Administrator or designee and is being used to monitor implementation of the POC and its new procedures.

4. The results of the monitoring completed under this POC were submitted to the QA/QI Committee for review and follow up.

Completion Date: December 11, 2014