STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145038	A. BUILDING _____ B. WING _____	C 04/27/2015

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HEARTLAND OF DECATUR	**444 WEST HARRISON STREET DECATUR, IL 62526**

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F 000	INITIAL COMMENTS Incident Report Investigation to Incident of 4/11/15 / IL76503	F 000		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to identify and assess one (R1) of two residents reviewed for history of tobacco use, for the ability to safely manage smoking materials. The staff failed to maintain control of R1's smoking materials per the facility resident smoking guidelines which allowed R1 to have unsupervised access to a lighter that resulted in a fire in R1's room. This failure had the potential to affect R1 and 17 other residents (R4-20) who were residing with in the same wing/fire zone when the fire occurred. The findings include: On 4/11/15 at 9:42 pm an initial incident report was sent by Administrator E1 to Illinois Department of Public Health (IDPH) Regional Office by facsimile. The report stated "CNA (Certified Nurse Aide) observed R1 violating facility smoking policy..There was no injury..	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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resident sent to hospital for further assessment/evaluation..full report to follow within 5 days." A final report for R1 was sent to IDPH office on 4/15/15 which stated "On 4/11/15 after 8:00 pm a small amount of smoke coming from the bedspread in (R1's) room. Employee immediately extinguished by folding sheet over.." The report stated a personal cigarette lighter was found in R1's purse...R1 had no injury and there was no property damage.

On 4/21/15 at 9:15 am Administrator, E1 and Director of Nurses (DON), E2 were interviewed about the incident. E1 stated that R1 was admitted two days prior to the incident. E1 stated "We did not know R1 was a smoker." E1 stated R1 no longer resided at the facility. E1 stated R1 had been sent to the hospital for a psychological evaluation the night of the incident after becoming combative and verbally abusive. E1 also stated that the Fire Department had also come out that night (4-11-15) and checked the room to make sure the area was safe.

Administrator E1 displayed the bedspread, sheets and blanket taken from R1's room on 4/21/14 at 9:45 am. There were burn holes in the sheet approximately six inches in diameter, burn holes in the blanket, three to four inches in diameter and a black char mark on the bedspread. There was burned paper and microfiber cloths, no cigarette remains were observed.

DON E2 stated on 4/21/15 at 9:15 am that "CNA E12 saw R1 in the hallway and there was smoke in R1's room. R1 had a lighter in R1's purse that we didn't know about." E2 stated Registered Nurse (RN) E13 evaluated R1 and there was no injury. E2 stated on 4/21/15 at 10:10 am that R1

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was the only active resident smoker in the facility at that time.

R1's Admission Record Report dated 4/10/15 documents R1 was admitted to the facility on 4/09/15. The report documented R1 was responsible for self and Z1 (R1's son) was the emergency contact. Progress notes list diagnoses of muscle weakness, malaise and fatigue. The Rehabilitation Referral form dated 4/09/15 listed diagnoses of Cerebral Vascular Accident, Osteoarthritis, Rheumatoid Arthritis, Hypertension. R1's Brief Interview for Mental Status (BIMS)status dated 4/10/15 identified R1 as cognitively intact.

R1's progress note dated 4/12/15 (for incident of 4/11/15) by RN E13 states "Writer was called to resident room by CNA (Certified Nurse Aide). Resident was in hallway outside of door to room. CNA reported the resident had used a (disposable) lighter to set (R1's) sheets that were on (R1's) bed on fire. The aide had extinguished the fire immediately, the resident was taken to a safe place to evaluate. No injuries were found and skin assessment was done as much as resident would allow. (R1) was very combative: spitting hitting, throwing change from (R1's) purse..When (R1) was asked why (R1) started the fire (R1) stated (R1) did not know. Writer was eventually able to retrieve lighter from resident. Resident room was searched for more smoking paraphernalia but none was found. (R1) continued to curse at staff and try to hit staff until (ambulance) arrived to transport to (hospital).."

R1's Admission Progress Notes dated 4/09/15 and subsequent notes through 4/11/15 documented no mention of R1 being a smoker or

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expressing the desire to smoke. There was no smoking assessment for R1 nor any mention of smoking addressed in R1's care plan in the closed record.

The facility "Action plan" dated 4/11/15 stated "A review with the patient immediately following the incident revealed (R1) had a lighter. No smoking evaluation had been done on this patient."

Staff interviews conducted on 4/21/15 and 4/22/15 with RNs E6, E13, Licensed Practical Nurse (LPN) E10, Admission and Marketing Director E5, and CNAs E7, E8, E9, E11, E12, showed that staff had knowledge that R1 was a smoker. R1 had been assisted by direct care staff to smoke outside during R1's stay at the facility (4/09/15- 4/11/15) at least once on the night of admission (4/09/15) by E7 and four times (9:00 am, 2:00 pm by E9, 3:30 pm, and 7:00 pm by E11) on 4/11/15 prior to the fire at 8:00 pm.

Admission and Marketing Director E5 stated on 4/21/15 at 2:30 pm that prior to R1's admission, son Z1 had asked if they allowed resident to smoke at the facility. E5 had informed Z1 the staff would walk residents outside 15 feet from the building to smoke. E5 stated she did not pass this information on to nursing staff assuming that an assessment would be done the first time R1 asked to smoke.

RN E6 stated on 4/22/15 at 1:50 pm that E6 was R1's admitting nurse on 4/09/15, second shift 2pm-10-pm. E6 stated R1 came in with own cigarettes and lighter which they kept on the medication cart. E6 stated R1 was taken outside to smoke by staff that night. E6 stated she should have documented R1's smoking in the admission

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progress note. E6 stated she did not pass the information to Activity Director E3 who does the resident smoking assessments.

CNA E12 stated on 4/21/15 at 11:30 am she had been working on the South Hall second shift (2:00 pm-10 pm) on 4/11/15 and R1 had been requesting to smoke after supper. E12 stated she checked with Nurse E13 who stated the resident had to be supervised. E12 stated she told R1 that other residents had to be assisted to bed and E12 would take R1 out later to smoke. E12 stated when E12 later (around 8:00 pm)came out of a room across the hall from R1's room, E12 saw R1 coming out of the bedroom into the hallway. E12 saw the reflection of a fire flickering in the window. E12 ran into the room and smothered the fire on the bed quickly by throwing a blanket on it. E12 stated that a coworker (unknown) had taken R1 out to smoke earlier in the shift.

CNA E11 stated on 4/21/15 at 2:20 pm that she had taken R1 outside to smoke two times on the 2:00 pm-10:00 pm shift on Saturday (4/11/15) at the request of Nurse E10 and CNA E7. E11 stated R1's box of cigarettes and lighter was at the Nurses station. E11 was given one cigarette and a lighter by E7. E11 took R1 outside to smoke approximately 3:45 pm. E11 handed R1 the lighter and cigarette, which R1 lit independently. E11 stated, after R1 had finished the first cigarette, R1 opened a purse and pulled out a second cigarette which R1 also smoked. E11 stated "It was my first time to take a resident out to smoke, R1 had more cigarettes in R1's) purse, R1 kept the lighter I gave (R1) and put it the purse and I brought R1 back to the unit." E11 stated R1 asked her a second time to smoke and E11 took R1 outside at 7:00 pm. R1 still had the

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lighter and a cigarette in the purse. R1 smoked one cigarette. E11 stated "I didn't know residents could smoke at the facility until that day and I didn't think anything about the resident having a lighter because (R1) also had cigarettes in (R1's) purse." E11 stated she had not been told during her training that she had to bring all the smoking supplies back to the nurse, after taking a resident out to smoke. E11 stated she was on break later that night when they told her that R1 had set the bed on fire.

DON E2 stated on 4/21/15 at 12:30 pm that her investigation on 4/11/15, confirmed "My staff did take (R1) out earlier that shift (2-10 pm on 4/11/15) to smoke. E2 said CNA E11 had stated that the R1 had R1's own lighter and cigarettes. E11 took R1 to the end of the sidewalk out front and allowed R1 to smoke." E2 stated on 4/21/15 at 2:30 pm "We had a fire, our CNA did not follow policy and procedure for smoking." E2 stated "In the past we have not allowed residents to carry their own cigarettes and lighter, they are always kept at the nurses station." E2 stated that R1 had only started asking to go out to smoke that day (4/11/15) and was not smoking before. E2 said at that time an assessment screening tool is completed on admission that asks if resident smokes, if the answer is yes then Activity Director E3 does a smoking assessment. R1's Admission screening tool dated 4/10/15 stated "No" for Tobacco Use.

Activity Director E3 stated on 4/21/15 at 1:10 pm that E3 screened R1 on Friday afternoon (4/10/15) and R1 told R3 that R1 did not not use tobacco. E3 stated she did not do a smoking safety assessment for R1 based on that answer. E3 stated that no direct care staff informed E3 -

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F 323	Continued From page 6 that they had been taking R1 out to smoke or an assessment would have been done. DON E2 stated on 4/21/15 at 3:05 pm that E2 was not aware that other staff had been assisting R1 outside to smoke earlier in the day on 4/11/15, nor earlier in the week. E2 stated on 4/21/15 at 2:30 pm that "It is always the directive for staff to bring the lighter and cigarettes back to the medication cart after assisting a resident to smoke. Typically we screen on admission and do an assessment at that time." The facility Smoking Guideline dated 11/2013 documents the purpose:"To determine if a patient is an Independent Smoker or an At Risk Smoker before the patient exercised the privilege to smoke while residing within the center and to establish smoking guidelines for all patients that desire to smoke at the center. The Guideline states "Provide interdisciplinary team members and center staff education on the Smoking Guidelines and Smoking Evaluation ...upon completion of the evaluation the IDT (Interdisciplinary Team), including the attending physician will make a decision whether the patient is Independent or an At Risk Smoker... If the patient is determined to be ... an at risk smoker, the patient is required to wear a protective smoking vest or apron if needed and is supervised while smoking...Direct personal supervision is provided to At Risk Smokers while smoking." The policy also states "Retention, storage, and distribution of smoking accessories are to kept under the control of center staff when not in use. This includes cigarettes, pipes, lighters, matches, lighter fluid, electronic cigarettes, etc. Staff members distribute smoking accessories to	F 323		

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F 323	Continued From page 7 patients at center designated smoking times." On 4/23/15 at 11:00 am Physical Therapist E18 stated he evaluated R1's mobility on 4/10/15. R1 required contact guard assist with a wheeled walker for ambulation 50 feet. R1 had pain in knees from a fall at home. R1 was utilizing a wheelchair and was not independently mobile throughout the unit when not in therapy. Staff were not ambulating R1 outside of therapy. Interviews with E2, and other nursing staff, activity and social service staff on 4/23/15 at 10-10:30 am had confirmed that R1 spent the majority of time in the bedroom and was propelled by staff to other areas in the building. The Bed Management Sheet dated 4/10/15 documents, 18 residents, (R1, R4-20) were residing on that wing at the time of the fire on 4/11/15. Five of the residents, (R4-R8) utilized oxygen concentrators in their rooms at that time per interview with RN E17 on 4/22/15 at 12:30 pm.	F 323		