STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145970	A. BUILDING _____ B. WING _____	C 08/13/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE NUR & REHAB CENTER	**2649 EAST 75TH ST CHICAGO, IL 60649**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
F9999	FINAL OBSERVATIONS 300.1210a) 300.1210b)6) 300.3240a) 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. All nursing personnel shall evaluate the residents to see that each resident reveives adequate supervision and assistance to prevent accidents. AN OWNER, LICENSEE, ADMINISTRATOR, EMPLOYEE OR AGENT OF A FACILITY SHALL NOT NEGLECT A RESIDENT. These regulations are not met, as evidence by the following:	F9999		

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F9999	Continued From page 6 Based on interview of staff, record review, review of incident reports and observations the facility failed to: Provide supervision and monitoring for 3 residents, R4, R5 and R6. 1. The failure of the facility to supervise and monitor R6 resulted in R6 smoking cigarettes and using matches on 7/24/04 while in the first floor dining room, resulting in him setting himself on fire, and causing burns to his upper trunk, both arms and hands, neck, ears, face, head and injury to his eyes, placing himself and co-residents at risk for injury. R6 was admitted to the hospital with 3rd degree burns to 30 percent of his body. 2. The facility nursing staff failed to provide the necessary supervision and monitoring for R5, while he was on the toilet, resulting in R5 falling on 6/18/04 after being left by E9 on the toilet unattended. R5 sustained bruises to his left shoulder and back, one 3 centimeter and one 5 centimeter lacerations on the lateral aspect of his left knee. 3. The facility nursing staff failed to provide the necessary supervision and ordered siderails for R4, who has impaired mobility, resulting in R4 falling onto the floor after being left unattended and without her siderails up. R4 received an injury to the right side of her head. Findings include: 1. R6 who has diagnoses of prostate cancer, cerebral vascular disease, coronary artery disease, diabetes mellitus, hypertension,	F9999		

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F9999	Continued From page 7	F9999		

dementia and altered mental status, was left unsupervised in the facility's 1st floor dining area on 7/24/04. Per interview of E7 and E8 both stated that no staff was present while R6 was smoking. E8 stated that she was alerted to R6 being on fire by other resident, who began to "scream and holler" as they ran to get some help. E7 and E8 were unable to remember who the residents were, but each verified that they were not anywhere in the vicinity of the dining room, while E6 was smoking, nor as he was on fire from careless use of smoking materials.

E8 stated that at first she had no idea how she would put the fire out, "because (R6) was lit like a torch and I was afraid I would catch fire, then I saw those drapes and I pulled them down from the window and smothered the flames which were shooting up all around him from his waist up to his face". E7 stated that she was in the process of caring for another resident, when she heard screaming coming from the dining room by residents and also by E8. E7 stated that when she got to the dining room she saw R6 "engulfed in flames". E7 stated that at that moment she was told by E8 and another staff person to go and call 911 as E8 tried to put the fire out . Both E7 and E8 stated that they were unaware of how R6 got any smoking materials and both stated that there was no staff present in the dining room during this incident on 7/24/04 as per policy.

The Chicago Fire Department came and administered care to R6 and then transferred R6 to the hospital by ambulance.

On observation of R6 on 7/30/04, R6 had 30 percent 2nd and 3rd degree burns on his torso,

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neck, face and ears. R6 was intubated since there was also significant airway involvement. Surveyor unable to talk to R6 since for pain management he was being sedated. Per Z1, Z2 and Z3(physicians) resident has had surgeries for skin grafts and other procedures 5 times (between dates of incident 7/24/04 and 8/11/04). On 7/30/04 per interview with Z1, R6's condition was "grave".

On review of R6's clinical records, and notes from E10 and E11, and smoking assessment for this resident, all state that R6 needed supervised smoking and that his "cigarettes are kept at nursing station". R6 was not allowed to carry smoking materials and required close monitoring when smoking.

Per interview of E7 states that R6 often had to be redirected with his smoking, because of smoking in the dining room or hiding cigarettes which staff were aware of. E7 stated that R6 would get his cigarettes lit by other residents or lit them himself and would already have them lit on occasions she discovered him smoking inappropriately or in unsafe place. Z4(family) stated that family members have not brought cigarettes to R6 in months since he has limited movement of his right hand and confusion and stated that because of this they would leave the cigarettes at the nursing station. Z4 stated that often facility residents would roll their own cigarettes in the dining room and light their own cigarettes with no staff in attendance. Facility policy and procedures and E7 and E8 confirmed that residents were supposed to smoke on the patio with staff monitoring.
Facility failed to provide safety and monitoring for

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R6 on 7/24/04 who was a known noncompliant smoker and failed to supervise resident while smoking.

2. R5 has diagnoses of cerebral vascular accident, gastric bleeding, hypertension and seizures and is wheelchair bound and needs assistance with transfers from wheel chair to bed and toilet. R5 was found on the floor in his bathroom, after falling off the toilet on 6/18/04, after being left alone by E9.

E9 and E6 both stated that R5 should not have been left alone while on the toilet and his records confirm that he needs someone with him at all times when placed on the toilet. E9 and E6 also stated that E9 had never worked with R5 before and was unaware of his care need for supervision while on the toilet and had not reviewed care needs with any staff prior to placing resident on toilet and leaving.

R5 received bruises on his left shoulder and his back, two lacerations to the lateral aspect of his left knee which were 3 and 5 centimeters. Physician was notified and orders given for R5 to receive tetanus 0.5 ml. (I.M.) intramuscularly and Tylenol 650 mg. as a (stat) right now order.

3. R4, who has diagnoses of mental status change, vascular disease, hypertension, resting tremors, urinary tract infections, esopharyngeal dysphagia, gastric feeding tube and who is totally dependent with her care and who is in need of bilateral siderails when in the bed as assessments and records reflect, was left unattended on 6/22/04 while in her bed with both siderails down after receiving care by E12. Per