STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145639	A. BUILDING _____ B. WING _____	11/08/2005

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CHICAGO RIDGE NURSING CENTER	10602 SOUTHWEST HIGHWAY CHICAGO RIDGE, IL 60415

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F 465	Continued From page 24 2 chairs looking at television and two residents were standing against the wall opposite the television next to the door that leads to an outside patio area. E5 was interviewed and asked why the room was not furnished. E5 stated that the residents can smoke on the patio but not in the Activity room.	F 465		
F 492 SS=E	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by : Based on direct observation, record review and interview the facility failed to provide services in compliance with the Skilled Nursing and Intermediate Care Facilities Code (77 Illinois Administrative Code 300) for all residents identified by the facility as having a serious mental illness. Findings include: 1) 300.4010b)c)d) - Comprehensive Assessment 2) 300.4030b)c) - Individualized Treatment Plan	F 492		12/2/05
F9999	FINAL OBSERVATIONS Licensure	F9999		

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F9999	Continued From page 25 300.1210a) 300.1210b)4) 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. Personal care shall be provided on a 24-hour, seven day a week basis. All nursing personnel shall evaluate residents to see that each resident receives 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 evidenced by the following: Based on review of closed clinical record and staff interviews, the facility failed to adequately monitor and supervise residents identified with unsafe smoking practices, and to prevent residents from smoking in their rooms and in areas where oxygen is in use, for 1 resident in a sample of 30 (R30), who suffered extensive burns to the facial area as a result of smoking cigarette while receiving oxygen therapy. The facility staff were aware that R30 was noncompliant with the smoking policy and identified him as an unsafe smoker.	F9999		

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F9999	Continued From page 26 Findings include: R30 was admitted to the facility on 9/27/04 with diagnoses including high cholesterol, anemia, chronic obstructive pulmonary disease, psychotic disorder, diabetes mellitus, schizoaffective disorder and seizure disorder. R30 had a physician ' s order for oxygen at 4 liters per nasal cannula as needed. According to the most recent resident assessment dated 9/28/05, R30 has difficulties with short-term memory and moderately impaired cognitive skills for decision making. R30 is ambulatory and has no limitations in range of motion. On review of the clinical record, there were several nurse's notes documenting that R30 would increase the flow rate of his oxygen. There was also documentation in the nursing notes and in the social service notes that staff found R30 smoking in his room while receiving oxygen via a nasal cannula. Upon further review of the clinical record, there were several nurse ' s notes and social service notes documenting R30's non-compliance with the facility's smoking policy. A Nurse's Note dated 5/6/05 documented, "resident found smoking in the room while the oxygen is on." The Nurse's Note dated 7/19/05 documented, " resident in room at bedside on oxygen at 4 liters per nasal cannula smoking a cigarette." Social Service Notes dated 10/8/04, 2/19/05, 5/6/05, 6/ 30/05, 7/20/05 and 9/28/05 all document that R30 was found in his room smoking cigarettes. The Social Service Notes also documented that smoking materials were removed from the resident's room and that the resident was	F9999		

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F9999	Continued From page 27	F9999		

counseled. There was no documentation that facility staff provided interventions to prevent further episodes of the resident smoking in his room while receiving oxygen.

On review of the Smoking Safety Risk Assessments dated 10/8/04 and 9/28/05, facility staff identified that R30 was an unsafe smoker. The Smoking Cessation Education Progress Notes dated 10/8/04 and 9/28/05 documented that R30 is non-compliant with the facility smoking policy. According to the facility House Rules and Behavioral Expectations guidelines, " smoking is only allowed in the designated smoking areas. Smoking is never allowed anywhere else in the facility."

On review of the Smoking Behavior Contract dated 10/8/04, it was documented that R30 refused to sign the smoking contract. It was documented in the contract that the social service department would "keep all cigarettes, lighters and matches." R30 was identified by facility staff as an unsafe smoker and was not allowed to have smoking materials in his possession. However, R30 shared a room with a resident that smoked; and who was allowed to have smoking materials in his possession.

The nursing note dated 10/2/05 at 6:25 PM documented, "informed by certified nursing assistant that resident was smoking in room while oxygen was in use." The Patient Transfer Form dated 10/2/05 documented that R30 was transferred to the hospital because, "resident smoking in room oxygen in use; combustion causing burns to face and nasal area." R30 was admitted to the hospital with a diagnosis of facial

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F9999	Continued From page 28 burns. During an interview on 10/27/05, E1 (administrator) confirmed that R30 suffered facial burns as a result of his smoking a cigarette while receiving oxygen via a nasal cannula. During the interview, E1 stated that R30 was identified as an unsafe smoker. E1 also confirmed that R30 was frequently found smoking in his room while receiving oxygen per nasal cannula. R30 ' s room was on the 1st floor north corridor. The resident ' s room was not in close proximity to the nursing station and too far away for staff to observe and/or monitor the resident ' s behaviors. R30 also shared a room with a smoker. During an interview on 11/2/05 at approximately 12:20 PM in the 1st floor dining room, R25 stated " I was in the room when he blew himself up. " R 25 stated that R30 smoked in his room daily and " it was an explosion waiting to happen. " According to R25, R30 never left the room and residents would come to the room and sell him cigarettes. R25 stated that R30 would frequently ask him for a cigarette and/or lighter. On 11/2/05 at approximately 12:30 PM, R35 stated that he was also in the room with R30 on 10/2/05 when the resident was smoking a cigarette while receiving oxygen therapy. R35 stated that R30, who wears an " oxygen mask " , put a very small cigarette butt in his mouth and attempted to light the cigarette with a lighter. R 35 stated that the oxygen and the cigarette lighter started to ignite causing a fire. R35 stated he saw sparks of fire in the oxygen tubing and that the resident ' s face was on fire. R35 stated that	F9999		

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he took his foot and stepped on the oxygen tubing that was connected to a large tank. R35 stated that R30 ' s facial area from the nose down was burned. R25 who was also in the room during the incident, stated that he ran to the nursing station to find the nurse. According to R 25, there was no staff on the floor at the time of the incident.

During an interview on 11/2/05 at approximately 12:35 PM, E13 stated that she was working on the 1st floor on 10/2/05 during the time of the incident involving R30. E13 stated that she was sitting in the nursing station when R25 approached and stated, " my roommate is on fire . " E13 stated that she and another certified nursing assistant ran to R30 ' s room. E13 stated that when she got inside the room, R30 was lying in his bed. The resident ' s face was black and his facial hair was on fire. E13 stated that the oxygen had been turned off. E13 stated that she was not sure who turned the oxygen off. E13 stated that she then ran back to the nursing station to call 911. E13 stated she looked in the resident ' s chart to determine if he was a full code. E13 confirmed that the nurse was not on the floor at the time. According to E13 the nurse was on her lunch break.

E13 also stated during the interview on 11/2/05, that R30 was an unsafe smoker. E13 stated that the resident would frequently smoke in his room while receiving oxygen. E13 also stated that she would remove smoking materials from the resident ' s room at least twice per week.

Facility staff identified that R30 was an unsafe smoker and that he was frequently found

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F9999	Continued From page 30 smoking in his room while receiving oxygen. Staff failed to determine how R30 obtained smoking materials in an effort to keep him safe, as he had already informed staff that he would not comply with the smoking policy. In addition, facility staff failed to identify residents responsible for selling cigarettes and other smoking materials to residents who have been identified as unsafe smokers. Facility staff failed to adequately monitor and supervise R30 to ensure the safety of all residents in the facility. 300.4010b)c)d) b) The IDT must identify the individual's needs by performing a comprehensive assessment as needed to supplement any preliminary evaluation conducted prior to admission to the facility. The assessment shall be coordinated by a PRSC. c) A comprehensive assessment must be completed by the IDT no later than 14 days after admission to the facility. Reports from the pre-admission screening assessment or assessments conducted to meet other requirements may be used as part of the comprehensive assessment if the assessment reflects the current condition of the individual and was completed no more than 90 days prior to admission. The assessment shall include at least the following: 1) A psychiatric evaluation . . . 2) Psychosocial assessment . . . 3) A skills assessment . . .	F9999		

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F9999	Continued From page 31 4) Oral Screening . . . 5) Discharge Plan . . . 6) Other assessments recommended by the IDT . . . 7) A structured assessment of resident interests and expectations regarding psychiatric rehabilitation . . d) Based on the results of all assessments, the PRSD or PRSC shall develop a narrative statement for the IDT review that summarizes findings regarding the resident's strengths and limitations; indicates the resident's expressed interests, expectations, and apparent level of motivation for psychiatric rehabilitation; and prioritizes needs for skill development related to improved functioning and increased independence. The IDT's assessment of overall rehabilitation focus for the resident will also be identified as one of the following levels: 1) Basic skills training and supports with opportunities for community integration; 2) Intensive skills training and supports with an increasing focus on community integration; or 3) Advanced skills training and supports with active linkage and use of community services in preparation for expected discharge within 6 months. Based on record review and staff interview the	F9999		

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F9999	Continued From page 32 facility failed to ensure that a comprehensive assessment was completed for 79 residents in the facility identified as having a serious mental illness. This includes 6 residents in the sample (R10, R11, R12, R17, R18, R23) and 73 residents outside the sample. Findings include: R10, R11, R12, R17, R18, R23 and the 73 residents outside the sample, were lacking the necessary assessments in order to determine their individualized needs as related to their mental illness. The facility was unable to produce an example of a comprehensive assessment that addressed all the criteria stated in the rule. The assessment issues were as follows: 1. There was no evidence of any skills assessment that identifies the skills the resident needs to acquire in order to function more independently. 2. There is no evidence of any oral screening. 3. There is no indication of any discharge planning that identifies the specific skills and needs that are required in order to prepare the resident for independent living in the community. On interview on 10/26/05, E8 (Director of Social Services) stated that she cannot do a discharge plan until the physician writes an order for a discharge plan. 4. There was no evidence of a structured assessment of resident interests and expectations regarding psychiatric rehabilitation .	F9999		

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F9999	Continued From page 33 5. There was no evidence of a narrative statement, written by the PRSC, for the IDT review that summarizes findings regarding the resident's strengths and limitations; indicates the resident's expressed interests, expectations, and apparent level of motivation for psychiatric rehabilitation. 6. There was no prioritization of needs for skill development related to improved functioning and increased independence. 7. There was no evidence of the IDT's assessment of overall rehabilitation focus for each resident being categorized according to the 3 levels (Basic, Intensive and Advanced Training Skills). 8. On interview, on 10/26/05, E8 (Director of Social Services) stated that the facility has been working toward establishing a program to meet the needs of their residents. She stated that the residents currently receive one to one episodic interventions. She stated that they have developed a program of group activities that has not yet been implemented. She confirmed that there have been no group activities in the facility since 7/05. 300.4030b)c) b) An ITP shall be developed within seven days after completion of the comprehensive assessment. c) The plan for each resident shall state specific	F9999		

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F9999	Continued From page 34 goals that are developed by the IDT. The resident's major needs shall be prioritized and approaches or programs shall be developed with specific goals, to address the higher prioritized needs. If a lower priority need is not being addressed through a specific goal or program, a statement shall be made as to why it is not being addressed or how the need will be otherwise addressed. Based on record review the facility failed to develop an ITP (Individualized Treatment Plan) that identified and prioritized the major needs of the residents, that listed the specific, individualized goals to address the higher prioritized needs, and that addressed the lower priority needs and how they would be addressed for 6 residents in the sample (R10, R11, R12, R 17, R18, R23) and 73 residents outside the sample with diagnoses that include Mental Illness . Findings include: 1. Review of the resident's care plans indicated that the residents needs are not prioritized and addressed with specific interventions. For example, R23 is a 38 year old resident and has diagnoses that include Schizophrenia, Paranoia and Depression. The resident is not currently enrolled in a day program and there are no group programs established in the facility. According to the Psychosocial/Mental Status Screening Assessment dated 8/2/05, and completed by E9 (PRSC), the resident is supposed to receive group interventions. The resident's plan does not address specific interventions for this resident.	F9999		