STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145942	A. BUILDING _____ B. WING _____	03/21/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEALTH AND REHAB CENTER	9525 SOUTH MAYFIELD OAK LAWN, IL 60453

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
F 365	Continued From page 54 facility menu revealed the meal was to include a salad with dressing. None of the residents on the floor were served the salad. E19 and E20 (diet techs) stated they both worked on 3/12/07 and the reason no salad was served was because there wasn't enough supplies to make the salad . The diet staff stated it is the food service director to make sure there is enough supplies on Friday before the weekend. There was no equal substitute provided for the salad.	F 365		
F 458 SS=B	483.70(d)(1)(ii) RESIDENT ROOMS Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation and room measurements, the facility failed to ensure that each resident in a multiple resident bedroom is provided with 80 square feet of living space. Findings include: The following three bed rooms provide 72.5 square feet per resident bed: Rooms 104, 108, 110, 111, 115, 116, 117 and 120. The following four bed rooms provide 71.2 square feet per resident bed: Rooms 106, 118, 119, 205, 206, 219 and 220. The following four bed room provides 71.2 square feet per resident bed:	F 458		

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F 458	Continued From page 55 Room: 121.	F 458		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)6) 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. 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. b) 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. These requirements are not met as evidenced by: Based on observation, interview and record review, the facility failed to adequately supervise four residents (R7, R6, R18, R21) who have been	F9999		

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F9999	Continued From page 56 identified as unsafe smokers. Three of the four residents (R7, R18 and R21) require continuous oxygen therapy. The lack of supervision resulted in 1 resident (R7), who has a diagnosis of Chronic Obstructive Pulmonary Disease (COPD), receiving burns to his face and having an exacerbation of his illness. Findings include: 1. Per record review, R7 has a diagnosis of COPD/Emphysema. According to the Nurses' Notes on 12/20/06 R7 was smoking in the basement Smoking room at approximately 12:40am while receiving liquid oxygen from a portable tank per nasal cannula. The oxygen ignited causing a fire being fed by the oxygen in the nasal cannula. Another resident in the room at the time pulled the burning nasal cannula from R7's face. R7 was transported to the hospital by ambulance complaining of burns to the face per ambulance records. R7 was admitted to the hospital 12/20/06 at 5:16am with diagnoses of COPD with exacerbation and facial burns. The facility was asked for an Incident report at the Daily Status Meeting, 3/13/07. No Incident Report was received. On 3/14/07 at approximately 2:30pm, R7 was interviewed in his room. The resident was asked about the fire on 12/20/06. R7 stated that he was in the basement smoking with his with oxygen going. The nasal cannula ignited. R7 stated he pulled the cannula off his face and another resident in the room at the time ran for help. R7 said his mustache and nose was burned. At the time of the incident, no staff were in the basement smoke room. R7 was asked if the facility changed any of the smoking rules after the	F9999		

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F9999	Continued From page 57	F9999		

incident. R7 stated that the facility started locking the basement smoke room after 9:00pm and stopped allowing residents to take their portable oxygen tanks into the basement smoke room.

On 3/13/07, at approximately 8:55am, R18 was observed coming out of the basement smoke room with his nasal cannula in place carrying his portable liquid oxygen tank. No staff were present in the smoke room at the time of the observation. E1 (Administrator) was told of the observation on 3/13/07 at the Daily Status Meeting. No changes were made to the smoking rules until the facility was told there was an Immediate Jeopardy.

2. On 3/13/07, during the Initial tour of the facility that started at approximately 10:20am with E3 (LPN), the odor of cigarette smoke was observed outside the resident room where R6 resides. At the time of the observation, R6 was lying in bed on his back with splints on both hands. The call light string and a clear plastic tubing was in the resident's mouth. R6 stated that he has to have the string for the call light in his mouth because he cannot use his hands. E3 stated that R6 has Multiple Sclerosis and is total care. The resident cannot transfer and needs to be fed. A pack of cigarettes was observed sitting on the resident's over the bed table. R6 was asked if he smokes and where does he smoke. The resident stated that he smokes on the patio. Per record review, R6 is an unsafe smoker. The facility's Smoking Policy states that "Residents who may pose a hazard to themselves and others with smoking materials may have their cigarettes, lighters and matches removed from them and kept at a designated location...." E16 (Social Service Director) was interviewed during the course of

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F9999	Continued From page 58	F9999		

the survey concerning the Smoking Policy and the unsafe smokers for whom she was responsible. E16 was asked for a list of unsafe smokers and what is the facility policy toward them. E16 presented a list with unsafe smokers and stated that residents caught smoking in unauthorized areas will have their smoking material confiscated. E16 was specifically asked about R6. E16 stated that she has to constantly confiscate packs of cigarettes from R6 because his wife and others give him cigarettes.

On 3/14/07 during the Daily Status Meeting, E1 (Administrator) acknowledged that R6's wife was bringing the cigarettes and assisting him to smoke. Also, that it was probably occurring in his room because the resident cannot be easily transferred from bed to recliner and taken outside.

R6's clinical record does not contain a care plan for unsafe smoking. The Social Service notes do not contain any documentation showing that the facility has done family counseling for smoking. E16 was interviewed 3/15/07 and asked if she counseled R6's wife about supplying him with cigarettes and the resident smoking in his room. E16 said, "No, I have never met his wife."

On 3/15/07, at approximately 11:00am, R6 was interviewed in his room as a Resident Interview for the survey. There was a heavy smell of smoke in the room. One pack of cigarettes and two lighters were observed on the residents bed side table. Another pack of cigarettes could be seen when the resident's bed side table drawer was open.
R6's room is approximately 30 feet away from R7's room (110) where staff was observed filling