STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145730	A. BUILDING _____ B. WING _____	C 04/04/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONTINENTAL CARE CENTER	**5336 NORTH WESTERN AVENUE CHICAGO, IL 60625**

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F 324	Continued From page 4 in room 2/1/07 and twice on 2/8/07 at 5am and later at 5:30. While the Immediate Jeopardy was removed on 3/31 when R2 and R3 were sent out of the building, the facility remains out of compliance at severity level 2 because the facility needs time to review changes in smoking policy and and time to monitor if changes in approach to smokers and their infractions are working to prevent further unauthorized smoking in rooms. The facility took the following steps to remove the Immediate Jeopardy: The residents affected were discharged the same day of the incident. The facility will re-assess and re-evaluate all residents that could be affected by the deficient practice. Facility will assess and identify all smokers and those with elopement risk and review and update the care plans. The facility smoking policy will be revised to indicate specific location of designated smoking area and all residents on admission and readmission who are smokers will be presented with smoking contract acknowledged by signature. All staff will be inserviced on accident prevention, hazards, from smoking and elopement. In servicing will be completed by 4/6/07. A monthly audit and review will be conducted by the DON/designee to review assessments are done and corresponding care plans are in place as part of Quality Assurance. Administrator and DON responsible.	F 324		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS	F9999		

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F9999	Continued From page 5 300.1210a) 300.1210b)6) 300.3240a) Section 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 psychological 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. Restorative measures shall include at a minimum the following procedures: b) 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Requirements are not met as evidenced by: Based on observation, interviews and record review, the facility failed to supervise one resident (R2) with documented history of smoking non compliance and who was found by nursing	F9999		

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F9999	Continued From page 6 staff several times smoking in the room. Facility failed to monitor, supervise this resident . R3 who is R2's roommate, is also a smoker and has a history of drinking and substance abuse. There was a fire in the facility on 3/31/07 at approximately 6:30pm in room (referred to as "XXX" for confidentiality) which is R2's and R3's room. The facility continued to leave R2 and R3 in Room XXX which is at the end of the long hall and the most distance away from the nursing station and their supervision. The cause of the fire is being investigated but determined to be either from R2's careless smoking or R3's use of a crack pipe in the room. A lighter and crack pipe were found in the room. Neither R2 or R3 were in the room at the time of the fire. The facility failed to protect R2, R3 and the other 120 residents in the building from careless smoking. Findings include: Surveyor entered facility on 4/1/07 and toured with E1. The Room XXX was taped to prevent entrance by and injury to other residents. The window had been broken out by Fire Department personnel who threw the low air mattress through the window per E1, and it was still outside the building resting against the wall severely involved. The headboard of the bed that belonged to R2 was evident with fire damage and it was R2's mattress that was involved, and there was water and smoke damage in the room. Per E1, the sprinkler went on immediately, the fire department came immediately and there were no residents harmed by the fire. Per E1, the fire plan was followed, residents were kept behind fire doors and not evacuated. The Fire Department	F9999		

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F9999	Continued From page 7 reset the sprinkler, assisted in clean up and left about 6:40pm. E1 stated there was a lighter found in the room, and R2 lit a cigarette defiantly in front of the Fire Captain who was interviewing him, even though he denied it was set by his cigarette. On 4/1 there was evident water damage to the carpet and ceiling tiles of the offices on the first floor directly under Room XXX. Room XXX was also noted to be at the end of the hall and far away from the nursing station situated in the middle of the 2nd floor. Per record review, R2 was new to the facility and was admitted on 3/7/07 with diagnosis of liver cirrhosis, anemia, paraplegia, ascites. He was in a wheelchair. Medications included Prevacid, Reglan, Aldactone, Keppra, Advair, Colace, Lasix. R2 was also receiving narcotic Hydrocodone for back pain that was changed to Norco because resident complained it was not helping. Screening revealed history of substance abuse and Risk Assessment revealed abuse, non compliance with smoking. R2 was not interviewed because both R2 and roommate R3 had been transferred out of the facility to two different hospitals for "behavior " per E1. At the time of the revisit on 4/3/07 R2 was still out and R3 had been readmitted and given a 30 day notice for drug use. When surveyor interviewed R3 who is also in a wheelchair, on 4/3/07, he denied that he had been smoking the crack pipe and insisted he was downstairs and not involved in the fire. Drug screen obtained from 3/31/07 hospital admission lists R3 negative for cocaine use . Per chart review of R2, Nurses notes clearly	F9999		

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F9999	Continued From page 8 document that R2 had aggression, noncompliance with alcohol and smoking several times in his room. 3/8-demanded urinal, verbally abusive to nurse, voided on floor, nurse filed police report. 3/8- smelled cigarette smoke in room 3/8 drunk, yelling in hallway 3/8 -hit nurse in face, smelled of alcohol 3/11- caught in bed smoking 3/12- caught smoking in room 3/13- smelled heavily of alcohol and cigarettes, speech slurred, gin bottle at bedside. Admin notified. 3/14 -resident threw urinal at CNA 3/19 -caught smoking in room 3/20 -noted smoking in room 3/21- complained Vicodin not helping. MD notified 3/31- altercation with other residents and R3-sent to hospital. The care plan for R2 addresses smoking, is dated 3/14/07 and includes approaches that Social Service is to give cues and reminders, intervene with behavior, search room because of hoarding alcohol, and monitor the room because of smoking history in unauthorized places. There is no evidence that follow up and reevaluation was done after several instances of unsafe smoking which put both R2 and rest of residents in danger. Social service designee notes of E4 address some of the smoking infractions and identify them, but there is no carry over to the nurses that actually found the smoking each instance. Per interview with E4, she is responsible for the implementation, evaluation, and update of the non compliance with the smoking program.	F9999		

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F9999	Continued From page 9 E1 stated building is non smoking and facility has designated smoking shed for smokers outside. The smoking area is immediately outside the first floor lounge with large smoking receptacles and there is also a covered screened area for use in colder weather. When toured on 4/3/07 with E3, there were 5 smokers and no staff. E4 provided surveyor with list of smokers, 13 residents, and identified R1 and R5 as smokers requiring added supervision. Record review of R1 revealed problems with supervision in area of elopement precautions and episode of smoking in the room on 2/1/07. R1 eloped on 2/15/07 and nurses notes reveal she was missing from 7:00pm until 10:00pm when returned to floor by CNA who stated police returned this resident. Record review of R3 revealed problems with drug use and smoking. R3 was also found to be smoking in room 2/1/07 and twice on 2/8/07 at 5:00am and later at 5:30. (A)	F9999		