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F 518	Continued From page 18 ID residents who smoke. That the facility has a right to search the residents room or belongings at anytime for smoking materials or evidence of any unsafe smoking practices. These meetings were held through out 5/15/08, 5/16/08, was repeated 5/20/08 and will be repeated twice a week with staff. 5. As of 5/15/08, smoking times are being done on the even hours under the direct supervision of staff outside the building. 6. On going in-services and counseling has been done with all smokers in order for them to join a smoking cessation groups. The safe smoking policy and procedure will also be discussed in resident council. 7. A quality assurance quarterly smoking audit has been done on all unsafe smokers and all others. Administrator or designee will be doing this weekly. 8. All employees have been re in-serviced on PASS & R.A.C.E. on 5/15/08, 5/16/08 and repeated on 5/20/08 along with the inservices. It will be displayed through out the building in three different languages. 9 A fire drill was performed on 5/21/08. It was simulated situation and was evaluated by each department head assigned to a unit. This drill will be done twice a month which will be announced and once a month unannounced. The administration will meet after each drill and reviewed by the Quality assurance.	F 518		
F9999	FINAL OBSERVATIONS	F9999		

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F9999	Continued From page 19 LICENSURE VIOLATIONS (NH 08-C0208) 300.610a) 300.670b) 300.1210a) 300.1210b)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.670 Disaster Preparedness b) Each facility shall have policies covering disaster preparedness, including a written plan for staff, residents and others to follow. 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	F9999		

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F9999	Continued From page 20 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These regulations are not met, as evidence by the following: Based on record reviews and interviews the facility failed to effectively implement and follow their policy and procedure regarding smoking, including monitoring non compliant residents on smoking restrictions, and failed to properly train all staff in emergency preparedness as in a fire emergency. This failure led to the deaths of R1 on 5/14/08 and R2 on 5/15/08, R3 sustaining deep third degree burns to the bilateral lower extremities on 11/22/07 and subsequently dying on 12/20/07 and, R4 not being supervised while smoking. Findings include: 1. R2 was a 76 year old male with multiple diagnosis to include DM (Diabetes Mellitus), Bi-polar disorder and history of CVA (Cerebro vascular accident). Review of R2's MDS (minimum data set) dated 5/11/08 showed that	F9999		

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the resident required supervision with bed mobility, limited assistance with transfers and extensive assistance with dressing. R2's MDS also indicated that the resident does not ambulate and uses wheelchair for locomotion.

Review of R2's latest assessment for supervision of smoking dated 3/10/08 showed that the resident had impaired decision making/judgement and had impaired short or long term memory. This assessment indicated that the resident cannot light his own cigarette safely, cannot hold his cigarette without burning himself, does not consistently and appropriately use an ashtray to manage ashes and self extinguish cigarettes, would borrow cigarettes from peers and staff in a manner that was inappropriate, and would smoke in non designated areas and non designated times. The assessment also showed that R2 had a history of smoking related incidents such as "burned clothing, drops ashes on self and throw lighted cigarettes in trash cans." According to the assessment R2 required supervised smoking by the staff. This assessment, for supervision of smoking was initiated by the facility on 11/23/07 and was reviewed every 90 days.

Review of R2's computerized documentation showed in-part the following:

- Social Service notes, 9/18/07 (1:24 PM), "Resident was observed smoking in the hallway." "Resident repeatedly denied smoking in the hallway and promised that he would never display such behaviors."

- Social Service notes, 10/9/07 (2:09 PM), "Resident continues to display unsafe smoking

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F9999	Continued From page 22 behaviors despite redirection and smoking restriction." - Nurses' notes, 12/30/07 (8:36 PM), "Room mate c/o (complaint of) about the resident that the resident is smoking in the room. Will report to social worker tomorrow." - Social Service notes, 12/31/07 (3:56 PM), "NOD (nurse on duty) reported that resident was found smoking in his room." "Resident denied smoking in his room but said that he would not do that in the future. SSD (social service director) reviewed that the resident continues to smoke in non-designated smoking areas despite repeated redirection from staff. Resident again stated that he would only smoke in the designated areas." - Social Service notes, 2/7/08 (9:00 PM), "Behavior: 6:30 PM Social worker called and informed that resident throw the lighted cigarette in the garbage can." - Nurses notes, 2/15/08 (12:35 PM), "Son came to see writer this morning because he was concerned that someone was taking lighters that he stated he brought resident. Writer explained to son that resident is listed as a non safe smoker. Son continued to bring cigarettes and lighters to resident." - Nurses' notes, 2/25/08 (10:34 PM), "resident was caught smoking in the room, the roommate is very upset because of this he cannot use the O2 (oxygen) when he needed. endorsed to am nurse to follow up with social service." - Social Service notes, 3/9/08 (2:17 PM), "Resident was witnessed by staff and residents	F9999		

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F9999	Continued From page 23 throwing his cigarette butt in the smoking room trash can. SS (social service) staff also observed resident holding a lighter. SS staff explained to resident that due to his current smoking restriction, he could not carry lighters." - Social Service notes, 5/1/08 (6:22 PM), "Resident's son often becomes agitated about resident's smoking restrictions and staff continually reviews smoking policy and resident's smoking restriction with resident and resident's son." - Social Service notes, 5/14/08 (5:18 PM), "Resident's son came to SS staff to get cigarettes for his father. SS staff counseled resident's son on smoking policy and resident's smoking restriction. Son was agitated and demanded his father's cigarettes." During interview held on 5/20/08 at 2:55 PM, R4 stated that he has seen R2 smoke in their room and that the son provided the lighter and cigarettes which made it possible for R2 to smoke in the room. During interview held on 5/22/08 at 12:40 PM, R7 stated that he was the former roommate of R2 and during that time he was using oxygen due to breathing problems. R7 stated that he has not actually seen R2 smoke in their room but has seen cigarette butts on the floor and has smelled smoke in their room multiple times. R7 further stated that R2 saves his cigarette butts inside his pocket, not really putting them out. During interviews held on 5/15/08 at approximately 9:30 AM, E6 (social service) stated that on 5/14/08 sometime before lunch, R2's son	F9999		

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F9999	Continued From page 24 asked for R2's cigarettes. E6 stated that the son was noted to be very agitated that day. E6 further gave the information that the cigarettes and lighter were given to the son who supplied the smoking paraphernalia. E6 also stated that, after giving R2's smoking paraphernalia, she did not know where they (R2 & son) went. Further, R2's son never returned the smoking paraphernalia nor did she know if R2 smoked all the cigarettes and what time the son left the facility. During another interview held on 5/22/08 at approximately 9:45 AM, E6 stated that on 5/14/08, she did not give a punch card to R2 or R2's son. E6 also stated that approximately 10 cigarettes were given to the son on 5/14/08. Review of R2's care plan dated 5/1/08 showed, "PROBLEM: Resident manifests noncompliance behavior with regards to smoking. Resident is noted to be smoking in his room, in the hallways and other places in the building where smoking is prohibited. This behavior makes his roommate upset for the reason that his roommate cannot use oxygen because he is smoking inside the room. Resident has been counseled by Administrator, SS and staff a number of times to no avail. He has been considered to be a non safe smoker. Resident is noted to be listening but not following what the smoking policy is telling him to do. Staff has been wondering where resident gets his lighter since all his smoking paraphernalia has been taken from him. When asked, he will not tell staff where he gets it." "APPROACH: Closely monitor resident with regards to his smoking." Review of the facility's policy and procedure regarding smoking stated in part, "Policy - No smoking- unless in designated areas.	F9999		

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F9999	Continued From page 25 Procedures - Residents who need supervision, while smoking, will have all smoking materials kept at nursing station or with Social Services, and will only smoke when supervised. Supervision - - Residents on smoking restriction will be given a punch card to be punched after resident is given one cigarette per hour. Staff will monitor residents on restriction while residents are smoking." Review of the facility incident report dated 5/14/08 (11:00 PM), "Staff smelled smoke and observed smoke coming out of room 330." Room 330 was R2's room per review of the facility roster. Interviews with E11 (CNA), E15 (nurse), E16 (CNA), E17 (CNA) and E18 (nurse) all stated that once they responded to the fire alarm on 5/14/08, they arrived on the 3rd floor unit with heavy smoke in room 330 and by the hallway near room 330. R2 and his roommate R1 were both taken out of room 330 by the fire department and were both sent to the hospital where they both expired. Review of R2's death certificate showed that the resident died on 5/15/08 at 12:24 A.M. with the cause of death, "Pending fire investigation." During interview held on 5/29/08 at 12:05 PM, E3 stated that on 5/15/08 at approximately 1:00 AM, E2 received a call from the Coroner's office informing the facility that R1 expired on 5/14/08 at 11:30 PM with the cause of death as smoke inhalation. 2. When interviewed on 5/16/08 at 3:05 P.M., E11-CNA (Certified Nurse Aide) stated that she responded to the Code Red (Fire Code) on 5/14/08 by proceeding to room 330. E11 opened the door of room 330 and saw the room as very	F9999		

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dark with heavy smoke and water coming from the ceiling. When E11 left, the door of room 330 was left open. E11 went to the nearby rooms and opened each and every window of room 329, 331, 322, 321, and the windows in the dining room. Employee 11, however, claimed that she closed all the doors before leaving the above mentioned rooms.

According to the facility's Fire Policy & Procedures no. 5, under Nursing, Dietary, and Housekeeping/Laundry Personnel, these departments, in response to a fire disaster in the facility, has to close all doors and windows.

The action of E11, during the course of the fire at approximately 11:00 P.M. on 5/14/08 (of opening the windows in room 329, 331, 322, 321, and the windows in the 3rd. floor dining room), was in direct contradiction to the facility Fire policy and procedure. Additionally, when the door of room 330 was left open, heavy smoke spread out on the third floor hallways and other areas where smoke could have seeped through. By not following a very important procedure (closing all doors and windows) E11 placed more residents and the other employees' life in harms way.

3. R4 is a 53 year old male with multiple diagnosis of Obsessive compulsive disorder, Schizoaffective disorder and Paranoia. Review of R4's MDS (minimum data set) dated 3/14/08, showed that R4 has modified independence with cognitive skills and decision making and is independent with all his ADL's (activities of daily living).

Review of R4's latest assessment for supervision

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of smoking, dated 2/22/08, showed that R4 had impaired decision making/judgement and had impaired short or long term memory. This assessment indicated that the resident provided cigarettes to peers who are cognitively impaired or who need supervision. R4 would also borrow cigarettes from peers and staff in a manner that is inappropriate. According to this assessment R4 required supervised smoking by the staff.

Review of R4's care plan dated 2/22/08 showed that the resident had been non compliant with facility smoking policies. The care plan indicated that the facility will monitor R4's smoking behaviors.

During interviews held on 5/20/08 at 2:55 PM, R4 stated that on 5/14/08, about an hour before the building fire alarm went off, he was inside the first floor canteen (designated smoking area) smoking with other residents (does not remember the names of the other residents). R4 told the surveyor that during that time there were no facility staff monitoring them while they were smoking.

Review of R4's cigarette punch card record dated 5/14/08 did not indicate that the resident smoked after 5:00 P.M..

4. R3 was a 68 year old resident who was admitted to the facility on 3/20/06 and had been diagnosed with acute psychosis, mood disorder, seizure disorder and possible dementia. Record review showed that, when initially assessed, R3 was not a high risk smoker but a safe smoker. Safe smokers, according to E3 (Administrator) and E5 (Social Service Director) are not provided supervision during smoking and may

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keep smoking paraphernalia in their possession. Incident reports reviewed did not show any incidents involving R3's smoking (until the fire incident of 11/22/07.) Review of the facility's computerized notes, dated 12/15/06, clearly stated that R3 had a potential for non compliance because R3 was a smoker and may have difficulty following the facility's smoking policy and that this was manifested by R3's smoking in inappropriate areas, a possible safety issue.

5. As written on the incident report prepared by E3, at about 2:30 P.M. on 11/22/07, E19-RN (Registered Nurse 3-11 shift) was near the nursing station when alerted by E20-CNA (Certified Nurses' Aide) who was shouting "fire, fire." E20 sounded the fire alarm and the receptionist announced a "Code Red." E3 then immediately grabbed the fire extinguisher and went to room 214. Employee 18-RN-ADON (Acting Assistant Director of Nursing) called 911.

As described on the incident report, when E19 opened the door of 214, a thick smoke was noticed. E19 then opened the bathroom door and saw flames on the floor. Also observed on the floor were burning clothing. E19 tried to extinguish the fire with the fire extinguisher. E19 also checked to see if any residents were in the room and saw R3 in 214-bed 2. R3, according to the report, was screaming and crying. E19, with the help of three nurse aides, transferred R3 out of room 214 to room 215 via a wheelchair. Further observed by E19 was the redness and a dark color on R3's lower extremities. While R3 being assessed by E19, 911 arrived and took over. The staff on the second floor, in addition to the other staff who responded to the code, immediately removed any residents in the

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F9999	Continued From page 29 hallway and rooms nearby. All hallways and other egress were cleared. The facility Investigation Summary did not state how the fire started or who started the fire. However when interviewed, E2 (Vice President of Operations) and E3 theorized that R3 may have started the fire. Their theory is as follows: R3 smoked on the first floor canteen on 11/22/07 (Thanksgiving Day) before 2:30 P.M. R3 usually did not wear a skirt but was wearing one on that day because of the Thanksgiving holiday. Perhaps while smoking, R3 accidentally dropped an ember of the cigarette on her diaper and only noticed that her skirt caught fire (through her diaper) when she was back to her room. (R3's room is located on the second floor and had to take the elevator, in a wheelchair, so as to get to room 214. R3 also had to pass the nurses' station which is directly in front of the elevator.) When R3 noticed that she was on fire, R3 shook her legs and stamped her feet. Nevertheless, R3 burned her legs. The other pair of the shoes, that R3 was wearing, had melted. E2, E3, and E5 (Social Service Director) all stated that R3 was not a problem smoker, that R3 did not sign a Resident Smoking Policy Contract and that R3 did not have any behavior regarding unsafe smoking. Interviews with the following staff on May 15, 16, 20, 21, 22, and 23, 2008 gave additional versions. These interviews suggested that the fire started or happened in the bathroom of 214 rather on the first floor Canteen Smoking room. - Employee 19.....saw R3 in bed when she saw the fire in the bathroom; R3 was not completely	F9999		

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F9999	Continued From page 30 in bed because R3's lower extremities (feet) were hanging from the bed; looked like R3 ran from the bathroom because of the position of R3 in bed; R3 was only wearing a shirt but not wearing pants, a skirt or any underwear. - Employee 20.....was able to partly open the door of 214, saw lots of smoke and heard the voice of R3 as coming from the bathroom saying, "I am burning"; did not go inside the room because of her asthma condition and only stayed outside room 214. - Employee 18.....staff were already inside room 214 when she arrived but the room still had a lot of smoke in the bathroom; did not see any cigarette, cigarette butts or lighter in the bathroom or in the resident's room but only "white stuff." R3 was taken to Lutheran General Hospital emergency room on 11/22/07 at 5:32 P.M. and was later transferred to Loyola Hospital burn Intensive care unit. R3 sustained third degree burn to both lower extremities. R3 later expired in the hospital on 12/20/07. (A)	F9999		