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F 514	Continued From page 213 ointment twice daily until heal.	F 514		
F 516 SS=E	483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or unauthorized use. This REQUIREMENT is not met as evidenced by: Based on random observations and record review the facility failed to safeguard medical records for residents on every floor by allowing charts to remain outside the nurse's station unattended and lock from anyone that enters the units. Findings include: The surveyor team from 1/11 and 1/31/2011 observed the each of the three resident's unit had resident's medical available for viewing. Part of the floor's resident records are place within the nurse's station in a shelving unit. The other part (approximately 10 medical records) of the records were stored in a portable	F 516		4/7/11

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F 516	Continued From page 214 storage unit. This storage unit was stored outside the nurse's station in the north-east hallway. This was noted to be out the visual control of any staff member in the nurse's station or the medication room. 1/10 and 1/11/2010 during lunch and dinner meal time and medication pass times the surveyor noted the facility's staff members were not in the area of the storage unit of the medical records. There was opportunity for anyone (visitors, resident and staff) to remove the medical record without any staff's knowledge. The surveyor attempted to review the medical record of R19. The record could not be located on the third floor unit. On 1/24/2011 at 3:30PM, the surveyor asked E15 (nurse) location of R19's medical record. E15 was not able to locate the medical record at the time of the request.	F 516		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.3240a) 300.3240b) 300.3240c) 300.3240d) 300.3240e) 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	F9999		

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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 300.3240 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)

b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act)

c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act)

d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act)

e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall

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F9999	Continued From page 216 immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) These Requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to implement their abuse policy and procedures for 5 of 24 sampled residents (R8, R11, R21, R22, R24). R11 reported an allegation of abuse against a staff member. R8, R21, R22 and R24 had incidents of abuse/altercations, facility policy not followed. The facility failed to (1) thoroughly investigate alleged resident altercations/abuse, (2) provide adequate protection to residents by removing the alleged perpetrator from resident contact immediately until the results of the investigation have been reviewed by the designated staff person, (3) report allegations to the Department, and (4) have a policy in place that is in compliance with reporting alleged abuse to the state survey agency. In addition, the facility failed to screen potential employees according to their "Pre-Employment Screening of Potential Employees" policy/procedure for a history of abuse, neglect and/or mistreatment of residents for 17 employees. Based on the review of the personnel files of E7, E46, E48, E28, E30, E49, E50, E31, E40, E13, E3, E47, E21, E51, E29, E19 and E12, they did not contain reference checks from previous employers.	F9999		

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F9999	Continued From page 217 These failures have the potential to effect all 126 residents in the facility. Findings include: 1. On 01/11/11 beginning at 11:30am, R11 was interviewed in the resident's room about allegations of abuse forwarded to the department in the form of a complaint. Although, R11 denied all of the allegations, additional information was presented by the resident as follows. R11's statement, as stated in part is, "In the early morning before E6 (nurse) came on I ask E6 for my inhaler, Spiriva. E7 (nurse) was off the clock and forgot to give it to me at 6:00am. E7 was standing right there. E6 said E7 wasn't going to give it to me after looking in that book. E7 came in my room as I was lying in bed, E7 threw it on the books on the over bed table. And said, "better hurry up or I will take the inhaler away." It frightened me when E7 burst in the room. E7 will push you to the edge, E7 got a quick temper, E7 got pissed off and grabbed the inhaler. E7 gets agitated, acts very mean to me and E7 makes me wait in line for meds. E 7 puts other residents in front of me. E7 has lots of enemies. I don't feel threatened, but feel uncomfortable; no, I'm not afraid. I feel uncomfortable in E7's presence. I told E2 (acting administrator) about this on Tuesday. I told E3 (director or nurses) on that Monday when E3 came to the floor. E7 worked this weekend, and E7 is making me feel uncomfortable. E7 don't say nothing to me, E7 don't call my name. I told E3 yesterday, E7's got nasty ways." This incident allegedly occurred 11/27/2010.	F9999		

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F9999	Continued From page 218 At 12:01pm, on 01/11/11, surveyor interviewed E6 (nurse) about the incident with R11 and E7. E6 stated, "R11 came to me (E6) and said, R11 didn't get the Spiriva. I looked in the drawer and I saw it down there, this was after 7:00am. I said to E7, R11 didn't get her inhaler. E7 took the inhaler to R11 in the room. But, I was hearing voices between the both of them, but I don't know what happened. Nope, nobody ask me and I didn't write anything. The tones and talk wasn't significant enough for me to go back to the room. E7 gave it about 7:00am. I just think you (surveyor) should explore it, talk to the (E3)." During the initial review of reportable and non-reportable incident reports on 01/10/11, there are no reports found related to the above mentioned incident involving R11 and E7. On 11/29/10, at 10:05am, a social service progress note written by a PRSC (psychosocial rehab services coordinator) in R11's record states that R11 stated the nurse (?) was in R11's "business," and R11 had to tell the nurse how she felt. R11 stated the nurse was doing things on purpose to agitate her. PRSC informed R11 to report to a staff member about how R11 felt she was treated, rather than addressing the nurse. Resident agreed to report any inappropriate actions by the staff to the administrator. Interview with E3 (director of nurses) on 01/11/11 at 2:05pm about the status of the incident involving R11 and E7. E3 stated, "The incident involving E7 and with R11 was reported to me in December. R11 complained R11 had been waiting in line for medicine, and R11 didn't get it.	F9999		

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R11 said the nurse (E7) gave everybody theirs, but wouldn't give R11 hers. I did an investigation and I did an inservice with the nurse." However, the facility failed to present evidence of a thorough investigation, or indication that E7 participated in an inservice during the time period in question.

Surveyor interviewed E3 on 01/11/11 at 2:40pm about reporting the incident to the State agency. E3 stated, "I didn't send the report to IDPH (Illinois Department Of Public Health). I didn't think of it as a abuse, when I talked to the patient, the patient said the nurse was rude, I didn't think it was abuse."

On 01/12/11, surveyor received two documents (record of complaint and employee report) dated 11/30/10 from the facility. The record of complaint states, "nature of complaint: resident complained that the nurse was rude and unprofessional when administering medication," signed by E3. And an employee (E7) report that stated, R11 complained about a nurse (E7) being rude in speaking to the resident. "States that the nurse said, 'you can't keep that, use it so I (E7) can take it back.'" E7 received a verbal warning according to the document signed by E3.

At 11:35am, on 01/12/11 surveyor interviewed E3 again. E3 stated in part, "E7 usually works 7-3pm shift on the second floor. You (surveyor) are the only one that told me the resident was uncomfortable. R11 has not told me (E3) was uncomfortable with E7, nothing about E7. It's the same, I assessed it along with E2 (acting administrator) as a complaint that the nurse was rude. What I see it as is a breach of professional

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ethics. I ran my abuse policy, I don't feel it is abuse. The patient was complaining the nurse was rude. E7 has been working the whole time from 11/27/10 to now, because I didn't feel it was abuse. I still don't feel it was abuse. E7 is on duty today, E7 will be here until 3:30pm, until I get an allegation of abuse of the resident. I didn't go to the resident yesterday because I didn't want R11 to feel in retaliatory way, because R11 had spoken to you (surveyor)."

At 12:00pm on 01/12/11, E2 (acting administrator) acknowledge being told about E7 being rude to R11.

Interview with E1 (abuse coordinator/administrator) on 01/12/11 at 2:45pm about the alleged incident involving R11 and E7, E1 stated, "Yes, I was notified about this complaint, maybe a day later, or two days later. I was involved, E3 reported this to me. I was confident E3 would investigate it, and handle it as a complaint. No, E3 did not report surveyor conversation with R11 about being uncomfortable. Now I sent a 24 hour investigation report to IDPH (Dept. of Public Health). I will continue the investigation."

On 01/12/11 at approximately 3:30pm, the team received several inservices dated 08/06/10, 01/04/11 and 01/06/11 with sign-in sheet attached. Topics include definitions of abuse, reporting, and thorough investigation of allegations of abuse.

After a thorough review of the documents, there is no evidence E3 or E7 attended them. The 08/06/10 sign sheet depicts a name that looks to

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F9999	Continued From page 221 be E7, but there is no corresponding signature. Interview with E1 (administrator) on 01/12/11 at 6:27pm related to the abatement plan for abuse, E1 stated, "If incident of abuse occurs on the weekend, we will fax the report on the Monday and this incident occurred 12/11/10 which was a Saturday." 2. R8 and R24 had the following unusual occurrence reports: -12/09/2010 at 8:45am, It was reported R8 slapped co-resident (R24) for no apparent reason, while smoking in the third floor smoking room. According to the report, the incident was witnessed, by several residents sitting in day room. R8 was taken to the second floor and given a PRN (as needed) medication and placed on one to one supervision. R8 was petition out to the hospital for a psychiatric evaluation and returned to the facility by 12/18/2010. Neither R8 or R24 had updated interventions regarding supervision or monitoring for the residents. On 12/25/2010 at 4:30am, R8 was found in the stairwell with another resident (R24) who was trying to hold her in a headlock. E29 (CNA/certified nurse aide) discovered the two residents in the stairwell and after the assistance from another CNA(E28) R24's hands were taken off R8 to release R8 from R24's grip. Both R8 and R24 were taken back to their floors and given PRN (as needed) medication. R24 was petitioned out to the hospital for a psychiatric evaluation and has not returned to the facility. The surveyor reviewed the facility's alleged abuse investigation of the two above incidents.	F9999		

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The investigation of 12/09/2010 consist and 12/25/2010 had no additional information beyond the incident report. There were no written statements or documented interview from any witnesses. Both investigation assessments stated both residents were unable to state what happen. The facility did not obtain the services of an interpreter to help with the interview of R8 at the time of the incidents. The facility failed to determine the reason for R8's attack on R24. Also the facility did not update either of the resident's care plans to put interventions in place to prevent the two residents from having another altercation.

According to the facility's policy and procedures for abuse investigation the facility will have an interview process. This includes the interview with the person(s) reporting the incident, an interview with the resident, and an interview with staff members having contact with the resident and the accused individual during the period of the alleged incident. Where appropriate, interviews shall take place with the resident's roommate, family members, visitors or others who were in the vicinity of the incident. None of these interviews were conducted.

The facility's policy and procedures for abuse states the facility will take steps to prevent mistreatment while the investigation is underway. Residents who allegedly mistreated another resident will be removed form contact with that resident during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well

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as the safety of other residents and employees of the facility.

R8 was sent out on 12/09/2010 to the hospital, however no additional recommendation was given regarding the resident's behavior. No changes to the care plan were done after the incident and before the next incident of 12/25/2010 for protecting either R8 or R24.

3. R21 has multiple diagnoses to include Schizoaffective disorder, Bi-polar with psychotic features and Deaf/mute. Review of the facility's unusual occurrence reports shows multiple incidents of physical altercations involving R21 and other residents. The dates are as follows:
- 6/18/10 at 12:45 PM, this incident was witnessed by a facility staff. The report states under, "Describe exactly what was observed: Physical altercation with co-resident." This report indicated that R21 complained of pain on the left jaw. Further review of the facility unusual occurrence reports shows that the facility identified a male resident involved in the physical altercation with R21 on 6/18/10. However, there was no complete investigation of this incident to include and determine what happen before, during and after the physical altercation. There was also no investigation report to include interviews with the residents and the witness.

- 9/5/10 at 4:30 PM, this incident was witnessed by co-residents. The report states, "Describe exactly what was observed: Physical altercation with peer, no injury noted. Staff separated and re-directed." Further review of the facility unusual occurrence reports shows that the facility identified a female resident involved in the

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physical altercation with R21 on 9/5/10. An investigation report was made regarding this incident on 9/5/10 at 4:30 PM, which indicated under, "Why did it happen? Unexplained." There was no complete investigation of this incident to include interviews with the co-residents who witnessed the incident to determine what happened before, during and after the physical altercation.

- 11/9//10 at 7:00 PM, this incident was witnessed by co-residents. The report states, "Describe exactly what was observed: Observed resident in physical altercation with co-residents." No injury was indicated on the report. Further review of the facility unusual occurrence reports shows that the facility identified a female resident involved in the physical altercation with R21 on 11/9/10. An investigation report was made regarding this incident on 11/9/10 at 8:00 PM, which states that R21 hit a co-resident at the back of the head. The investigation report states under, "Why did it happen? Residents had argument over money and cigarette." However, there was no complete investigation of this incident to include interviews with the co-residents who witnessed the incident to determine what happened before, during and after the physical altercation.

4. R22 has multiple diagnoses to include Chronic mental illness, Schizoaffective disorder and Paranoid Schizophrenia.
Review of R22's unusual occurrence reports shows an incident dated 7/31/10 at 9:20 PM. This incident was witnessed by facility staff. The report states, "Describe exactly what was observed: Observed resident in physical

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F9999	Continued From page 225 altercation with co-resident." No injury was documented. There was no complete investigation of this incident to include the co-resident involved and the interviews with the residents and the witnesses to determine what happen before, during and after the physical altercation. During an interview held on 1/26/11 at 2:00 PM, E2 (Acting Administrator) stated that the facility cannot find the investigation report regarding the physical altercation incident on 7/31/10 involving R22 and a co-resident. 5. At 9:15am, surveyor requested reference checks from previous employers from E1. However, by the end of the shift, the team did not receive any reference checks or verbal confirmation from E1 about the reference checks. The facility failed to follow their abuse policy and procedure as it relates to investigation of allegations, screening/employee training, and protection of residents as follows: -Investigation of allegation: Supervisors shall immediately inform the administrator or designee of all reports of potential mistreatment. Upon learning of the report, the administrator or designee shall initiate an incident investigation; appoint an investigator; the appointed investigator will follow the Resident Protection Investigation Procedures: (completion of a written report on the status of the investigation within 24 hours of the occurrence; an interview with resident; interview with any witness to the incident;	F9999		

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F9999	Continued From page 226 if the accused individual is an employee, review the personnel file to check for references; background check; and documentation of orientation and training; where appropriate, interviews with the resident's roommate, or others who were in the vicinity of the incident; and interview other employees to determine if they have ever witnessed other incidents of mistreatment involving the accused individual). -Pre-Employment Screening of Potential Employees: Initiate a reference check from previous employer(s), in accordance with the facility policy. -Training of employees: On a periodic basis, staff (and supervisory personnel) will receive training on allegations of abuse, neglect, or theft, and how to monitor and correct inappropriate or insensitive staff actions, words or body language. - Protection of Residents: The facility will take steps to prevent mistreatment while the investigation is underway. Employees of this facility who have been accused of mistreatment will be removed from resident contact immediately until the results of the investigation have been reviewed by the administrator or designee. Employees accused of possible mistreatment shall not complete the shift as a direct care provide to residents. (A)	F9999		

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F9999	Continued From page 227 300.690a) 300.690b) 300.1210a) 300.1210b)3) 300.1220b)6) 300.3240a) Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. 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. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:	F9999		

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F9999	Continued From page 228 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nurisng staff and recorded in the resident's medical record. 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. 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehesive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reivewed at least every three months. 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)	F9999		

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F9999	Continued From page 229 These Requirements were not met as evidenced by: A) Based on observation, record review, staff interview and facility's policy and procedures, the facility failed to ensure that residents received appropriate and adequate supervision as it relate to the following: -Residents smoking in non-designated areas and/or having evidence of smoking in residents' rooms and during unsupervised smoking. -The failure to assure resident floors and residents access areas including stairwells were monitored for smoking by staff. -The failure to ensure residents identified with smoking behaviors were reassessed for appropriate smoking privileges. -The failure to monitor the use of an illegal substance by a known substance abuser. These failures occurred for 7 of 24 residents inside the sample (R2, R7, R8, R15, R16, R17 and R19) and 11 residents outside the sample (R26, R27, R28, R48, R51, R54, R55, R56, R57, R58 and R59). These failures resulted in R17 sustaining an incident of hair on forehead being singed/burned while staff was lighting a pipe for him to smoke, as well as sustaining burn injuries to the fingers at different times during supervised smoking. Findings includes: 1. During the initial tour with E3 (Director of Nurses) on 01/10/11, R17, who was noted to be alert but aphasic and using gestures, was sitting in a motorized wheel chair. There was a	F9999		

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communication board on R17's wall across the room that E3 stated R17 uses for communication. Surveyor also observed a slightly soiled, white dressing intact to R17's right index finger. R17's left hand was noted laying flaccid in his lap.

During interview regarding the dressing on R17's finger, E3 stated, "R17 burned his finger while smoking." E3 added that R17 has supervised smoking.

Review of the facility's wound care assessment by Z4 (wound care doctor) indicated that R17 had burn injuries to left hand on 04/26/10 and 05/03/10. Further review of nurses notes dated 11/13/10 indicated that R17 had burn injury to 2nd and 3rd finger of right hand.

During interview on 01/20/10 at approximately 10:40am, Z6 (family of R17)confirmed that R17 has supervised smoking and stated to surveyor, "Im not aware of burn to R17's left hand. R17 can't use the left hand. Since the car accident that caused his brain injury, he hasn't been able to use his left side." Z6 continued, "I think R17 had 3 burns to the right hand and a couple months ago R17's hair on his forehead was singed when staff was lighting his pipe and looked away." Z6 removed R17's cap and showed surveyor hair having been singed/burned.

Later this day at 1:40pm, E14 stated during interview "Im not aware that R17 having a burn to the left hand. Im aware of that blister he got to the right finger. This happened around December (2010)." Upon further interview, E14 added that

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F9999	Continued From page 231 R17 got 2 burns to the right hand in November (2010). On 01/18/11 at 2;10pm, E25 (treatment nurse) was observed to treat the right index finger of R17. After the soiled dressings were removed surveyor noted a black/blue color to the nailbed. The first layer of R17's finger was missing. R17's finger was clean, free of signs and symptoms of infection. E25 stated during interview, "I would say this is a first degree burn because it started out as a blister that happened in December (2010)." E25 continued, "R17 has monitored smoking. I don't know how R17 got this burn." E25 proceeded to provide treatment to R17's right index finger. 2. On 01/11/11 at 2:25pm upon prompting, Surveyor entered the south/west rear stairwell of the 2nd floor and noted a strong, fresh smell of cigarette smoke with some haziness in the area. R8 was noted to rise from a sitting position on the step and extinguish a cigarette with her foot on the floor and immediately leave the area. There were 3 cigarette butts and scattered ashes noted on the floor in this area of the stairwell. On the next day at approximately 2:45pm, upon prompting, Surveyor again entered the same stairwell and observed R16 sitting on the step. There was a strong smell of fresh cigarette smoke with haziness in this area. Surveyor continued down these steps but returned to this area within 1-2 minutes. Upon entering the stair well again, R16 immediately stood up and started to flee the area. There was still dense smoke and strong cigarette smell remaining after R16 started to flee the area. Surveyor also observed a lighted smoldering cigarette on the floor. Surveyor	F9999		

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immediately prompted staff to this area. E12 (psychiatric rehabilitation service coordinator)responded and stated R16 is not a high risk smoker. R16 was observed ambulating down the hallway during this interview with E12. Surveyor identified R16 as the person observed smoking in stairwell. R16 is noted to have a language barrier, using gestures and slow speech. E12 asked R16 if he was smoking in the stairwell. R6 nodded his head up/down indicating yes. E12 counseled R16 at this time.

3. R15 is a 54 year old male, originally admitted to the facility on 5/14/09. Review of R15's records shows that the resident has multiple diagnoses to include Schizo-affective disorder, paranoid Schizophrenia and alcohol abuse.

On 1/13/11 at 4:55 PM, R15 was observed actively smoking at the 4th floor back stairwell. Surveyor informed E45 (nurse) and E46 (CNA) of this observation. During an interview held after this observation on 1/13/11, E45 and E46 both stated that R15 was not supposed to smoke in the stairwell. E45 and E46 also added that residents go in and out of the back stairwell and they are not supposed to.

Review of R15's smoking safety risk assessment dated 5/14/09 and 11/12/10 shows a score of "0" which indicated that the resident may independently handle smoking material. The 11/12/10 indicated under comments, "Resident appears to be a safe smoker."

Review of R15's Pre-admission screening (Mental Health Assessment) dated 8/9/2005 indicated under, "O. Fire setting or arson:

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F9999	Continued From page 233 Accidentally got his jacket on fire earlier this year." Review of R15's individual treatment plan dated 11/24/10 indicated that the resident has nicotine dependence, compulsive smoking. One of the interventions indicated, "PRSC (Psychiatric Rehabilitation Service Coordinator) will counsel and re-direct resident when behavior is observed." On 1/18/11, R15's nurses' notes and the social service progress notes were reviewed. There was no documentation regarding the resident's behavior of smoking in inappropriate place on 1/13/11. There was also no care plan in place on 1/18/11 to reflect and address the inappropriate smoking behavior of R15 on 1/13/11. Review of the non compliant smoking behavior log-in sheet for R15 shows documentation that the resident was again found smoking in inappropriate places on two separate occasions after 1/13/11. On 1/21/11 at 2:25 AM and on 1/24/11 at 3:30 AM, R15 was found smoking in the 4th floor bathroom. On 1/25/10 at 11:00 AM, surveyor asked E8 (PRSD/Psychiatric Rehabilitation Service Director) for R15's smoking care plan. E8 handed the surveyor a smoking care plan initiated on 1/13/11 (which was not available for review on 1/18/11) with the date updated on 1/24/11. This care plan shows evidence that the facility did not update R15's care plan for smoking after he was observed smoking the bathroom on 1/21/11. R15's care plan also did not indicate any change in	F9999		

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F9999	Continued From page 234 approaches/interventions to address R15's smoking infractions. The facility failed to supervise R15 after an incident of non-compliance regarding smoking in an inappropriate place on 1/13/11. R15 was again observed smoking in a non-designated areas on 1/21/11 and 1/24/1, which could post a potential hazard for the resident and other residents' safety. 4. R26 is a 46 years old male originally admitted to the facility on 10/8/1998 with multiple diagnoses to include Schizo-affective disorder. On 1/13/11 at 4:59 PM, R26 was observed actively smoking at the 4th floor common bathroom. Surveyor informed E45 and E46 of this observation. During an interview held after this observation on 1/13/11, E45 and E46 both stated that R26 was not supposed to smoke in the bathroom. Review of R26's smoking safety risk assessment dated 11/12/10 shows a score of "6" which indicates that the resident requires supervised/controlled smoking management. This assessment also indicates under comments, "Resident requires supervision and monitoring - smokes in his room." Review of R26's Behavior tracking and episodic intervention response forms showed that on two occasions R26 was observed to be non-compliant with smoking on 7/20/10 and 10/13/10. On the incident on 7/20/10, the facility intervened by providing verbal cues/instruction to stop the resident from the behavior and smoking	F9999		

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management to include extinguish smoking material, search the room/area for hazardous materials, require the resident to empty pockets and turn over all hazardous material, remove all hazardous products (Cigarettes, lighters, matches, rolling papers, etc.), apply behavior consequences (i.e., remove/restrict a privilege). On the incident on 10/13/10, the facility intervened by providing verbal cues/instruction to stop the resident from the behavior.

On 1/18/11, R26's nurses' notes and the social service progress notes were reviewed. There was no documentation regarding the resident's behavior of smoking in inappropriate place on 1/13/11. There was also no care plan in place on 1/18/11 to reflect and address R26's inappropriate smoking behavior on 7/20/10, 10/13/10 and 1/13/11.

Review of the non compliant smoking behavior log-in sheet for R26 shows documentation that the resident was again found smoking in an inappropriate place after 1/13/11. On 1/23/11 at 9:30 PM, R26 was observed by the CNA smoking marijuana in toilet. Review of R26's nurses' notes dated 1/23/11 shows no documentation of the marijuana smoking incident.

On 1/25/10 at 11:55 AM, surveyor asked E8 for R26's smoking care plan. E8 handed the surveyor a smoking care plan initiated on 1/13/11 (which was not available for review on 1/18/11) with the date updated on 1/24/11. This care plan shows evidence that the facility did not have a smoking care plan in place on 7/20/10 and 10/13/10. Further review of this smoking care

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F9999	Continued From page 236 plan which was updated on 1/24/11 shows no plan to address the marijuana smoking incident. The care plan also did not indicate any change in approaches/interventions to address R26's smoking infractions. The facility failed to supervise R26 after an incident of non-compliance regarding smoking in an inappropriate place on 1/13/11. As a result, R26 was again observed by the facility staff smoking marijuana in a non-designated area on 1/24/11 which could post a potential hazard for the resident and other residents' safety. 5. R27 is a 60 year old male, originally admitted to the facility on 6/10/10. Review of R27's records shows that the resident has multiple diagnoses to include Schizo-affective disorder, Bi-polar disorder and alcohol dependency. Review of the non compliant smoking behavior log-in sheet for R27 shows documentation that the resident was found smoking in his bedroom on 1/4/11 at 9:30 AM. Review of R27's nurses' notes dated 1/4/11 (11:00AM) states, "Up in wheelchair. Alert. Appetite good no c/o (complaints) voiced. In room smoking. Social Services made aware. Compliant with meds. Will continue to monitor." Review of R27's social service progress notes shows no evidence that the social service was informed and had addressed the resident's smoking in the room. Review of R27's smoking safety risk assessment dated 11/11/10 showed a score of "0" which indicates that the resident may independently handle smoking material.	F9999		

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Review of R27's care plan dated 11/11/10 indicated that the resident has nicotine dependence. However this problem did not reflect any approaches/interventions to address R27's smoking behavior. This care plan was also not updated/revised after the incident of inappropriate smoking on 1/4/11.

During an interview held on 1/18/11 at 1:00 PM, E8 stated that she does not recall being notified of R27's smoking in the room. Per E8, if the smoking issue was reported and addressed, it would be written on the social service notes.

Review of R27's Illinois State Police report shows documentation that the resident had a history of Arson on 3/6/1989. R27's Criminal History Analysis Security Recommendation report indicated that the resident is a moderate risk, which indicates that, "The resident requires closer supervision and more frequent observation than standard or routine for most residents in an open facility. Regular monitoring should be attentive to behavioral changes that may signal a need for closer observation or sustained visual monitoring on a time- limited basis. Periodic assessments should ascertain whether the level of supervision is sufficient."

The facility failed to supervise R27 who has a history of arson to ensure smoking compliance. As a result, R27 was observed smoking in his room on 1/4/11 which could post a potential hazard for the resident and other residents' safety.

6. R19 smoking as documented on the smoking behavior log in sheet:

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F9999	Continued From page 238 -09/20/2010 9:00AM, smoking in the bathroom and smoking material taken -11/14/2010 2:25(AM/PM?) smoking in the bathroom and talked to resident. Social service documentation/resident teach form from 8/30/2010 stated smoking in room, verbal counseling given. States understanding of smoking policy. R19's care plan with dates of 8/30 and 11/30/2010 identified a nicotine dependence, compulsive smoking. However there is no specific goal for this problems and no planned interventions for non-compliance with the facility's smoking policy. 7. R28 is a 49 years old male with multiple diagnoses including Schizo-affective disorder, convulsions and history of transient cerebral ischemia. Review of facility sign in and out sheets shows evidence that R28 goes in and out of the facility daily without indicating the facility departure and arrival time, as well as his destination. Review of R28's social service progress notes shows the following documentation: - 4/26/10, "Resident was seen using an illegal substance while sitting in the day room." - 4/29/10, "Worker was informed that resident tested positive for marijuana." - 5/27/10, "Resident was seen purchasing an illegal substance in the community by facility	F9999		

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staff. Resident attempted to bring the illegal substance in the facility. This writer along with security staff was able to remove the illegal substance from resident's pocket."

- 8/4/10, "Resident was seen using marijuana in the bathroom on the 4th fl. (floor)."

- 8/15/10, "Resident was seen smoking marijuana in the day room of the 4th floor - 8/14/10."

- 9/30/10, "Resident was seen smoking marijuana in the facility day room."

- 11/21/10, "resident was seen by facility staff using marijuana in the day room."

Further review of the social service progress notes shows evidence of substance abuse while in the facility, dating back 2009.

Review of the facility policy regarding room searches, contraband items and removal of contraband dated 3/19/2009 states, "This organization reserves the right to conduct inspections if there is reason to suspect/believe that a resident has contraband items/materials in his/her possession. These items include, but are not limited to, alcohol, illicit (street) drugs, weapons (including sharp objects), and smoking materials (if the individual has proven to be dangerous and irresponsible with smoking related items)." This policy and procedure enumerated items that are not allowed in a resident's possession which includes drugs, especially non-prescribed/illicit drugs. Furthermore, the policy also states, "Individuals

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALL AMERICAN NURSING HOME	5448 NORTH BROADWAY STREET CHICAGO, IL 60640

(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
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who choose to violate this policy will be removed from the premises and may be subject to arrest."

During an interview held on 1/26/11 at 11:10 AM, E8 (PRSD) stated that R28 started on an intensive substance abuse program in September 2010. Per E8, this program is held in the facility 4 x/week for 2 hours, every Monday, Tuesday, Thursday and Friday from 6:30 PM to 8:30 PM. E8 was asked why R28 was just started on an intensive substance abuse program in September 2010 when R28 has a long history of substance abuse while in the facility dating back to 2009. E8 had no response.

The facility failed to monitor R28, a known substance abuser, and the facility failed to conduct inspections to ensure that every time R28 returns from outside pass that no contrabands such as marijuana are brought in the facility to ensure the safety of R28 and the other residents.

8. During 4 days of the survey 01/10, 01/11, 01/12 and 01/13/11 room 301 was noted with an odor of cigarette smoke, and cigarette butts on the floor in the room at the foot of R 54's bed. There were no residents in the room at the time of the observations. E40 (case manager) was presented this information, and interviewed at 11:10 AM about the problem. E40 stated, "R54 just got here, R54 is not a problem."

At 11:15 AM, R54 entered the unit, and was questioned about the cigarette butts at the foot of R54's bed, and the odor of cigarette smoke. E54 stated, "That Black women and Caucasian women is smoking in there. R48 is doing most of