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F9999	FINAL OBSERVATIONS STATE LICENSURE FINDINGS: Section 300.1030 Medical Emergencies a) The advisory physician or medical advisory committee shall develop policies and procedures to be followed during the various medical emergencies that may occur from time to time in long-term care facilities. These medical emergencies include, but are not limited to, such things as: 3) Traumatic injuries (for example, fractures, burns, and lacerations). Section 300.1210 General Requirements for Nursing and Personal Care	F9999		

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F9999	Continued From page 20 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: 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 300.3020 Codes and Standards d)2)D) Facility shall establish and enforce written procedures to prohibit smoking in resident sleeping rooms and corridors. Smoking is permitted only in controlled areas. These REGULATIONS are not met as evidenced by: Based on observation, resident medical records, facility 3-8-05 staffing schedule, facility smoking policies, facility and fire department incident/ investigative reports reviewed, and interviews: 1) The facility failed to provide adequate	F9999		

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F9999	Continued From page 21 supervision to one resident (R1) on the 5th floor secured Dementia unit with a diagnosis to include psychotic disorder and who was identified through multiple social service and nursing entries and in the current care plan in the medical record to be an unsafe smoker and an elopement risk. On 3-8-05 sometime between 6:00PM and 6:38PM, R1 left the 5 South secured Dementia unit and exited the 5th floor via the 5 North wing (an adjoining unoccupied unit) elevator, went downstairs to the first floor smoking room, obtained cigarettes and a box of matches, returned to 5 North, entered and empty room (504), and closed the door without staff knowledge. R1 laid down in the window bed of room 504 and lit a cigarette that started a fire that disintegrated the entire mattress. The fire also involved the bed, headboards, privacy curtain, the wall behind the bed, and the bathroom door. R1 sustained 3rd degree burns to 25% of his body resulting in an extensive hospitalization, bi-lateral lower extremities being amputated, multiple skin grafts, intubation with mechanical ventilation, and a 35% mortality rate of survival as a direct result of the fire. At the time R1 left the secured unit there was only one staff person alone on the unit (E4), a nurse aide, with 33 dementia-type residents picking up dinner trays. There were 2 other staff (E7-nurse and E5-nurse aide) assigned on the secured unit and down stairs on the first floor at dinner break when R1 left the secured unit. 2) The facility failed to provide continuous staff supervision on the 5 South secured Dementia unit during the 3-8-05 fire from the time E5 left the 5 South unit to investigate the smoke odor on the 5 North unit until the time E7 returned to the 5	F9999		

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F9999	Continued From page 22 North Unit from dinner break. 3) The facility failed to assure visitors' knowledge of 5 South (secured unit) security and safety measures to prevent residents from leaving the unit without staff knowledge. 4) The facility failed to follow the smoking room policy, stating that the smoking room is under security camera surveillance, which is monitored at the second floor nursing station 24 hours a day . Based on facility's fire safety procedures, in-services, facility's incident report dated 3/8/05, interviews, and written statements, the facility staff: 1. Failed to follow their own fire procedure/ protocol (RACE). 2. Failed to evacuate R1 to a safe area. 3. Failed to contain the fire in room 504 allowing the thick black smoke to engulf the whole 5th floor Northwest corridor resulting in R1 sustaining mild smoke inhalation rendering R1 semi-unconscious in addition to R1's third degree burns to 25% of his body which required hospitalization, bilateral lower extremities amputation, skin grafts and intubation. E3 (Certified Nurse Aide-C.N.A.) also required emergency treatment for smoke inhalation due to the fire/smoke not being contained to room 504. The Findings include:	F9999		

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F9999	Continued From page 23 E7 (nurse) stated during a 3/11/05 telephone interview that on 3/8/05 on the afternoon shift there was a census of 33 residents on the 5 South secured Dementia unit. E7 stated that he was the nurse on that unit with 2 nurse aides (E4 and E5). 3/8/05 staffing schedule validated this staffing. E7 said that at 6:15PM he left the fifth floor and went downstairs to the first floor staff dining room for break and did not return until after 6:40PM. E7 also stated that he saw E5 in the staff dining room sitting at a nearby table with other staff about 20 minutes after he arrived in the staff dining room. E4 and E5 both stated during 3/10/05 individual phone interviews that on 3/8/05 E7 and E5 went downstairs on break and left E4 alone on the 5 South unit. E4 stated she was picking up dinner trays and realized that R1 was missing and was unable to locate R1 on the 5 South unit. E4 said that she observed Z5 and R2 returning on the unit and approached Z5 and asked if Z5 knew where R1 was. Z5 told E4 that R1 had gone down to the 1st floor with Z5 for a cigarette and that he was right behind her, but he was not. E4 waited for E5 to return to 5 South and notified E5 of R1 having left the unit with Z5 and not returning. E4 then left the 5 South secured unit to go downstairs to the first floor to look for R1, leaving E5 alone with 32 dementia type 5 South residents. E5 stated that shortly after E4 left the 5 th floor to look for R1, E5 smelled smoke-like odors coming through the exit doors from an adjoining unoccupied unit (5 North). E5 opened the fire doors between 5 South and 5 North to investigate the smoke odor and observed R1 lying on the floor in the doorway of	F9999		

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F9999	Continued From page 24 room 504, with the top half of R1's body protruding through the door into the hallway and the lower half still in the room. E5 stated she pulled the fire alarm and came back to pull R1 out of the room and noticed R1's socks are on fire. E5 stated that she used water to extinguish the flames on R1's socks. E5 left R1 on the floor to get a fire extinguisher from 5 South and returned to extinguish R1's feet and the room fire. While E5 was on 5 North with R1 and the fire, the 32 residents on 5 South were without any staff supervision for a period of time. E4 returned to 5 North from downstairs and observed E5 fighting the fire in room 504. E4 stated that she immediately obtained a fire extinguisher on 5 North and joined E5 in her efforts to fight the fire in room 504, still leaving 5 South unit residents without any staff supervision. E4's 3/8/05 written statement notes that E4 assisted spraying the fire with fire extinguisher, then proceeded to open windows in rooms 503, 502, 501, 529 and 528 before exiting the fifth floor via the north stairwell, to the 5th floor and walking through the fourth floor to the south stairwell up to 5 South unit. E7 stated during 3/11/05 phone interview, that he returned to 5 South via the South stairway 2 minutes prior to E4 returning to 5 South. Facility failed to supervise 2 residents that are identified as high risk smokers (R1 and R2) on 3/8/05 sometime between 6pm and 6:38PM in the 1st floor smoking area with cigarettes and matches accessible to them. Z5 stated during 3/11/05 telephone interview that on 3/8/05 between 6 - 6:15PM while Z5 and R2 were exiting the 5 South secured unit to go downstairs for a cigarette, R1 approached Z5 and asked to join them, stating R1 had staff permission to leave the	F9999		

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unit. Z5 stated that there were no signs by the 5 South exit doors saying not to take any resident off the unit without staff knowledge. E5 stated during 3/11/05 phone interview that the only sign by the 5 South exit door that she remembers was a notice on the panic bar of the door about the 15 second delay. E4 stated during 3/11/05 phone interview, that the only sign she remembered by the 5 South exit door was one instructing visitors how to use the door code panel. E4 and E5 both stated that R2 was admitted to 5 South secured unit from another unit in the facility a couple of weeks prior to 3/8/05.

E1 told surveyor that E4 and E5 have worked on the 5 South secured unit greater than 9 years. Z5 stated that the only instructions staff every gave her about safety on the unit was to not let residents see her punching in the door code on the panel. Z5 stated that she took R1 and R2 off the secured unit, onto the elevator on 5 North unit and down to the first floor smoking room. Z5 left R1 and R2 unsupervised in the 1st floor smoking room, alone, while Z5 went out to the receptionist desk, obtained a restroom key, used the restroom and returned the key to the receptionist desk. Z5 also stated that she had left her cigarettes and a book matches on a table in the smoking area when she left to use the restroom and that upon return to the smoking area, Z5 noticed her book of matches were missing. Z5 said that R1, R2 and Z5 went back up the elevator to the 5th floor 15 - 20 minutes later, exited the elevator onto 5 North unit and walked down corridor and into 5 South secured unit, where Z5 was approached by a nurse aide (E4) and asked where R1 was. Z5 replied to E4 saying that R1 was right behind her but that when

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F9999	Continued From page 26 Z5 turned around R1 was not there. Facility and fire department incident/ investigation reports and staff interviews revealed that R1 must have ducked into room 504 when Z5, R1 and R2 were walking down 5 North corridor from the elevator to the 5 South entrance doors, closed the room door, got into the window bed and started smoking a cigarette. The bed and resident caught fire. R1 attempted to use his hands to pat out the fire causing 1st degree burns on the hands and then removed his pants that were still on fire. R1's current care plan stated that R1 is to be supervised when smoking cigarettes and is not to have independent access to smoking materials. R1 has 13 documented incidents of smoking cigarettes in unauthorized areas, including on the secured unit between 12/31/03 and 3/08/05. R1's medical record documented 4 previous incidents of R1 getting out of the 5 South secured unit without staff knowledge (twice on 02/01/04 and once on 02/03/04 and 02/29/04). During the 02/02/04 incident, R1 actually left the building and was walking outside in the parking lot, when a staff person driving into the parking lot noticed R1. In addition, R1 eloped from a prior nursing home 8/18/03, a week prior to being admitted to this nursing home (8/25/03). R1 is identified by facility to be at moderate risk for elopement. Facility's smoking room policy states that the smoking room is under security camera surveillance, which is monitored at the second floor nurses station 24 hours a day. On 3/10/05 surveyors observed a security	F9999		

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camera in the upper corner of the smoking room that is connected to a 9 inch monitor at the 2nd floor nurses station. On 3/10/05 E1 (Vice president of operations) stated that this monitor is not under 24 hour observation by any staff because all residents that use the smoking room are either independent smokers or being supervised by a responsible adult. During 2nd floor tour on 3/15/05 at 2:10PM with E1, surveyor observed no facility staff in the 2nd floor nurses station or in visual control of the monitor. This 2 nd floor monitor visualizes 3 areas in the facility: the first floor lobby, the first floor side entrance door and the first floor smoking room. Surveyor and E1 observed the monitor fixed on 1st floor lobby, not the smoking room. E1 changed the monitors viewing section to the smoking room by pushing a button at which time the surveyor observed several residents using the smoking room via the monitor.

Z4 (Surgeon) stated during 3/16/05 telephone interview that R1 sustained 3rd degree burns to 25% of his body requiring a right through the knee amputation and right posterior thigh skin grafts on 3/11/05 and a left below the knee amputation with left posterior thigh skin grafts on 3/15/05. Z4 also stated that R1 is intubated and on mechanical ventilation as a result of smoke inhalation and the multiple surgeries. Z4 also stated that R1 has only a 35% mortality rate of survival as a result of these burns.

Per facility's incident report, staff interviews (E3, E4, E5) and written statements (E5, E6): On 3/8/ 05 at 6:35 p.m., E4 (CNA) discovers that R1 is

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missing from 5 South. E4 is the only staff person on the floor (5 South) with 32 dementia residents due to E7 (Licensed Practical Nurse) and E5 (CNA) being on break. E4 sees Z5 (R2's significant other) and R2 returning to 5 South and asked them if they saw R1. Z5 states that R1 is right behind them and turns to see that he is not there. E5 returns to 5 South and E4 tells E5 that R1 is missing. E4 and E5 continue to look for R1. E4 leaves 5 South,via the fire doors to 5 North, passing room 504, to the elevator to go search for R1. As soon as the elevator doors shut, E4 hears E5 call for E4. E5 had also passed through the fire doors from 5 South to 5 North (an unoccupied unit) and observes R1 on the floor with half his body in the room and the other half his body outside of the room 504. There was a lot of black smoke. E5 stated that she left to pull fire alarm. Returns to pull R1 out of room but his feet are on fire. E5 stated to use water to extinguish the flames on R1's feet. E5 leaves R1 on the floor to get extinguisher.

When E4 arrives to room 504, E4 observes E5 using an extinguisher into room 504 while R1 remains half in and out of the room. E4 runs and gets another extinguisher to help E5. E4 says she hears E5 telling R1 to move to the 5 North Nurses' Station which is directly across from room 504. E4 returns with extinguisher to help E5 . E5 states that E5 was extinguishing the flames in the room while E4 was extinguishing the flames in the toilet room. E4 stated that the smoke was so thick and black it was hard to breathe. E4 stated that she heads down the 5 Northwest corridor to the stairwell (Northwest fire exit) where E4 encounters E3 (CNA). E3, with

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F9999	Continued From page 29 fire extinguisher in hand, stated he saw E4 as he entered the 5 Northwest corridor from the stairwell and stated he saw E5 at the nurses' station and R1 sitting in a chair at nurses' station. The door to room 504 remained open with thick, black smoke in the corridor and room 504. Inside room 504, there was melting plastic with sparking but no real flames seen. E3 stated to place only one foot into room due to the thick black smoke. E3 stated he used the extinguisher in room 504 and needed to get another extinguisher from the 5th floor Northwest corridor. When E3 returned with second extinguisher, E3 stated that he observed R1 on the corridor floor in front of room 504 and did not see E4 nor E5. E 3 stated he assumed they left the area. E3 stated that R1 was kind of unconscious and did not answer any questions. E3 stated he pulled R1 down the corridor to the 5th floor Northwest Stairwell and opened the stairwell door and was yelling for help. As E3 opened the stairwell door, the firemen were there. E3 and 2 other firemen carried R1 down the stairwell to the 1st floor lobby. Review of facility's fire procedure reflects that R.A .C.E. is to be used. R.A.C.E. is an acronym: R is Rescue the patient. A is pull the fire alarm. C is close the door. E is use the extinguisher. The procedure further explains to evacuate all residents horizontally, moving them behind fire doors. Smoke doors will close automatically. Notify supervisor of location of fire. Receptionist or nurse in charge will announce the location of	F9999		

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F9999	Continued From page 30 fire. Staff will close all doors and windows to resident rooms. The facility's fire procedure is further broken down into two more categories, fighting the fire and persons on fire. Fighting the fire reflects that after the fire has been discovered, residents and visitors evacuate from the area, and pull the fire alarm. Obtain nearest fire extinguisher... then there are instructions on how to use the extinguisher to extinguish the fire. The instructions say never use direct contact on person. The other subcategory, persons on fire, states if person is on fire, cover the person with blanket and "pat" the fire out. If no blanket available, roll the person over, from side to side, until fire is out. Review of fire safety in-service dated 12/14/04 shows that E6, E3, E4, and E5 attended the in-service. There was no explanation or brief synopsis of what the in-service covered. Interview with E5 on 3/11/05 at 4 pm. via phone stated 3 different scenarios when asked what she has been in-serviced to do during a fire. First, E5 stated that she would pull the fire alarm, obtain an extinguisher, spray for the fire, and close door. Then on E5's 2nd attempt, E5 states that she would pull the alarm, remove the patient, extinguish fire, and close door. Then E5 changes it to remove the patient, pull the alarm, extinguish fire, and close door. Surveyor asked E5 if room 504's door was left	F9999		

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F9999	Continued From page 31 open or closed. E5 stated that she closed the door to room 504 and then the fire department showed up. Interview with E5 on 3/10/05 at 4:15 p.m. via phone stated when she was searching for R1, she smelled smoke and went to 5 North. Upon entering 5 North, E5 saw R1 on the floor with room 504 door open and smoke. E5 states she leaves to pull the fire alarm and returns to pull R1 out and sees that R1's socks are on fire. E5 states that she uses water to extinguish the fire. E5 states that she leaves the area to get a fire extinguisher so she can put out the fire and extinguish R1's feet. Interview with E4 on 3/11/05 at 2:25 pm via phone stated not to recall the last fire safety in-service she had attended. When E4 was asked about the steps she should take during a fire, E4 was unable to say and was not sure. Interview with E3 on 3/11/05 at 12:50 p.m. via phone stated to hear the fire alarm on 3/8/05. E3, who was working the 4th floor, made sure the residents on 4th floor were behind closed doors, grabbed a 4th floor extinguisher, and went upstairs via northwest stairwell to 5th floor Northwest Corridor. E3 states, upon entering the 5th floor Northwest corridor, he sees E4 in the corridor at the northwest stairwell and R1 sitting in a chair at the 5th floor North Nurses' Station along with E5. E3 states that the door to room 504 is still open. E3 states that there was a lot of black smoke but he was able to see when he first entered the unit.	F9999		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
F9999	Continued From page 32 E4 was asked when was the last fire safety in-service he attended. E4 stated not to remember. E4 stated to know to rescue the patient away from fire, pull alarm, and close the door. When asked if E3 closed the door, E3 stated not to know if he had closed the door all the way. E3 stated he went to the hospital emergency room, was evaluated on 3/8/05, and sent home. On 3/9/05 at night, E3 was still coughing. Therefore, E3 went back to the hospital and the emergency room did chest x-rays, an EKG, given aspirin, and sent E3 home. E3 stated to be okay during the interview. During the second interview with E3 on 3/17/05 via phone, E3 states that he used the 4th floor fire extinguisher and needed another extinguisher which he obtained from the 5th floor Northwest corridor and upon his return, E3 saw R1 on the corridor floor in front of room 504 and no sight of E3 and E4. E3 stated he assumed E3 and E4 had left the area. E3 stated that he dragged R1 down the 5th floor northwest corridor to the northwest stairwell where E3 was greeted by firemen. Interview with E9 (Registered Nurse - RN) on 3/17/05 via phone stated that the supervisor, E6 (RN) informed E9 of the fire. E9 stated that there was an alarm but it only lasted for 2 to 3 seconds so E9 thought it was just a test. E9 stated he went up the northwest stairwell to 5th floor and saw E4 opening the door to stairwell. There was a lot of black smoke. E9 instructed E4 to come down to 4th floor and go up the other (southeast) stairwell to 5th floor South Unit along with E9. E9	F9999		

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	145662	A. BUILDING _____ B. WING _____	C 03/23/2005

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F9999	Continued From page 33	F9999		

and E4 enter 5 South and saw E5 and E7(Licensed Practical Nurse). E9 stated he went back to 2nd floor and called a code red (fire) because he never heard any alarms. E9 stated that after he called the code red, E9 still never heard any alarms.

Interview with E6 on 3/1105 at 3:45 p.m. stated to hear the fire alarm on 3/8/05 at 6:30 p.m. and heard someone shouting there is a fire on 5th floor. E6 attempted to go up northwest stairwell but due to the thick black smoke, E6 turned around and went up the southeast stairwell to 5 South. E6 stated he checked to see if 5 South residents were okay since E6 was the shift supervisor. E6 stated not to go into 5 North because the firemen were there.

Interview with E7 on 3/11/05 via phone stated he finished his break at 6:40 p.m. on 3/8/05 and was leaving the dining room/break room when he heard the fire alarm. E7 headed up the southeast stairwell (due to elevator was not working) and went to 5 South. E7 stated he was on the unit for 2 minutes before seeing E4. E7 stated that E4 helped E7 assist 5 South ambulatory Residents to the 1st floor lobby. Residents that could not be removed from the floor were left in their rooms and the door closed.

E7 stated to have attended a fire safety in-service about a month ago. E7 stated that during a fire, the alarm should be pulled, confine the smoke, close the doors, remove residents, and extinguish the fire with fire extinguisher.

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F9999	Continued From page 34 Throughout all staff interviews (E3, E4, E5), staff failed to close the door to room 504 to contain the smoke and fire, failed to removed the R1 from the area, and failed to use correct procedures to extinguish flames on R1's body. Interview with Z7 (fireman) on 3/17/05 at the fire station stated that the call came in between 6:30 pm to 7 pm. The firemen arrived and went to 5th floor via stairwell. There was a heavy white smoke on 5th floor by fire exit. Z7 stated that they (himself and other firemen) heard coughing in hallway; it was E3 that the firemen pulled into the stairwell. Z7 stated that it was very difficult to breathe due to the smoke. When E3 was asked if there were others on the floor, E3 pointed down the hall. Z7 stated that one could only see a matter of feet due to the thick white smoke. Z7 stated that 2 firemen went down the 5th floor corridor and found R1. E3 was trying to remove R1 from the area. They had gotten 2 rooms down from room 504 (half-way between the stairwell and room 504). Z7 stated that room 504's door was open and the Dementia Doors and fire doors were closed. Z7 stated that the smoke became black as the firemen got closer to room 504. The firemen used a special thermal imagining device to tell which bed was on fire. Z7 stated that the mattress was burned up causing a few flames but mostly smoke. There were no accelerants seen and the sprinklers did not go off because it did not get hot enough in the room. Interview with Z11 on 3/17/05 at the fire house stated that when he arrived to the facility on 3/8/	F9999		

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F9999	Continued From page 35 05, R1 was being brought down in a blanket and had pretty bad lower extremity burns. R1 was completely naked, alert and not complaining of pain. Z11 stated that R1's legs were oozing blood and the skin was sloughing into a tear-drop shape at the bottom of R1's feet. Interview with Z12 on 3/17/05 at the fire house stated that R1 complained of pain in the ambulance. R1 stated pain was a 10 on a scale of 1 to 10, 10 being the worst. Z12 stated R1 was given Advanced Life Support and morphine. R1's bilateral lower (knees down) extremities had second and third degree burns but got worse toward the feet. R1 had first degree burns to hands and minor smoke inhalation. Interview with Z4 (Surgeon) on 3/16/05 at 2:45 p. m. via phone stated that R1's right lower extremity was amputated at the knee with posterior thigh skin graft on 3/11/05 and on 3/15/ 05, R1 underwent a below the knee amputee on left leg with a posterior thigh skin graft. The intubation resulted from the smoke inhalation and multiple surgeries. Z4 stated that R1 sustained a 35% mortality survival rate as a result of these injuries. The facility is located in a five story building with a full basement. The building construction type is Type II (2,2,2) Protected - Non - Combustible and consist of the following: * Exterior - Walls are of 4" face brick with 8" and 10" concrete block backup and drywall	F9999		

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F9999	Continued From page 36 interior finish. * Structure - All floor slabs and roof deck are 8" thick pre-cast concrete slabs supported by protected steel beams and columns. * Corridors - All corridors have 3 5/8" metal studs with 5/8" drywall on both sides and extending full height to the structure above. * The building has an automatic sprinkler system, and smoke detectors in corridors, at smoke door and hazard areas. During the event of the fire on 3/8/05 at approximately 6:30 p.m., the facility "Fire Safety Procedures" were not followed as required in NFPA provision 19.7.1.1. 2000 Existing Life Safety Code. The facility's Fire Safety Procedures for all fires reflects RACE - RESCUE, ALARM, CONTAIN, EXTINGUISH was not met. Activity during the the fire event appears to have been focused on extinguishing the fire while RESCUE - rescue the patient was not the priority and CONTAIN was overlooked and could have been met simply by closing the door to room 504 - the location of the fire.	F9999		