STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145308	A. BUILDING _____ B. WING _____	09/12/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD CARE	50 NORTH JANE ELGIN, IL 60123

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F 469	Continued From page 26 The findings include; During team meetings on 9/8/and 9/10/08, surveyors discussed the presence of flies in the facility. On 9/10/08, surveyor toured the outside of the building, observing for window screens on the first floor. Five window screens were observed missing with another 10 noted to be either damaged or loose fitting. The window to the Activity Office was missing a screen, with the window to the room open. Flies were observed during the kitchen survey of 09/08/08. During initial tour on 9/8/08 at approximately 11:30am, R9 was observed in bed asleep with three flies on the bed covers over R9. R9 is a totally dependent resident that is unable to use her call light or "shoo" the flies away herself. Again on 9/9 at 12:05pm flies were found on R9, this time one was on her nose by the nares. R9 was asleep. A third observation was made on 9/10 at 10:30am that while R9 was being given care by the CNA, flies were still flying over and landing on R9.	F 469		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210a) 300.1210b)6) 300.1220b)3) Section 300.610 Resident Care Policies	F9999		

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F9999	Continued From page 27 a) The facility shall have written policies and procedures, governinng all services provided by the facility. These written policies shall be followed in operating the facility. 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 psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 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 comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs.	F9999		

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F9999	Continued From page 28 These requirements are not met as evidenced by: Based on observation, record review and staff interview, the facility failed to consistently implement, assess, and respond in a timely manner to multiple residents smoking unsafely in the facility thereby putting all 193 residents at risk. The facility failed to implement their current smoking plan in a consistent and timely manner and assess risk factors after each infraction in an individualized approach in the medical records and care plans to deal with residents who continued to smoke and had multiple episodes of breaking the smoking rules. This occurred on all three shifts. The present smoking plan developed by the facility determined that high risk smokers were to be transferred to a supervised unit. Surveyors noted smoking in the facility continued on this identified supervised unit and, in fact, one resident (R12) was noted to be smoking in his room on 9/9/08 at approximately 4:10pm on this supervised unit by a surveyor--even after the facility was notified of the failure to respond to smoking dangers. Thirteen residents were caught smoking multiple times in their rooms or bathrooms from July 1, 2008 to September 7, 2008. (R12, R7, R18, R29, R17, R8, R31, R32, R5, R24, R35, R33, R34) Observations began on the initial tour 9/8/08, when multiple rooms were noted with evidence of smoking such as cigarette ashes and butts on the floor and strong odor of fresh cigarette smoke	F9999		

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F9999	Continued From page 29 noted in the rooms. A facility hall monitor acknowledged catching two of the residents in their room smoking. There were no documented interventions for these incidences. Surveyors identified multiple smoking infractions by looking at daily communication logs and reviewing care plans. It was determined that present facility smoking approaches were not effective or applied consistently and timely in safeguarding the facility residents from danger of inappropriate and unsupervised smoking. Findings Include: From facility documentation on the daily logs, R12 was the worst offender, and was noted to be smoking in unauthorized areas on 7/1, 7/6, 7/7, 7/10, 8/5, 8/15, 8/26, 9/7, and by surveyor in his bathroom on 9/9/08. R12 had no access to the community and had left sided hemiplegia. The facility failed to determine how the resident was obtaining the smoking materials. The following residents were also discovered smoking in unsupervised and unapproved areas: R7 found smoking on 8/6, and 9/7/08. R18 found smoking 7/12, 8/10, 8/22, 9/2/08. Identified by facility as high risk. R29 found smoking 7/12 and 7/24/08. R17 found smoking 7/28, 8/8, 8/13, 9/3/08. Identified by facility as high risk. R8 found smoking 7/4, 8/13/08. R31 found smoking 7/8, 7/23, 8/22/08. R32 found smoking 8/6/08. R5 found smoking 7/22, 7/23, 7/28, 8/5, 9/2/08. Identified by facility as high risk. R35 found smoking 8/22/08 along with R24, R33 and R31 on same day 8/22/08. R34 found smoking 7/22, 8/11/08.	F9999		

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F9999	Continued From page 30 1. R12 was admitted on 2/9/06 with diagnoses including Schizophrenia, bipolar disorder, COPD, seizures due to brain injury, and left sided hemiparesis. Surveyor identified this resident as a problem smoker on initial tour on 9/8/08 after noting evidence of smoking in the room. Assessment by facility on 4/08 identified R12 as a smoking risk and he was placed on the 2500 supervised wing where he continued to smoke in his room or bathroom. Care Plan last dated 8/7/08 included approaches and interventions of: 1. orient resident to smoking policy, 2. place on smoking program (not allowed to have smoking utensils), 3. orient to designated smoking area and times, 4. monitor behavior and place on 2500 wing for increased supervision. No evidence in records that R12's care plan was revised as smoking continued or increased supervision was given to monitor his behavior as the plan was not working. Review of medical record for R12 fails to show that the care plan was implemented after each smoking infraction. Social Service progress notes jump from 2/08 to 7/16/08. Facility staff E5 (PRSC) was asked if there were any additional notes available and he stated "no," and made a phone call to E4 who is R12's PRSC to confirm this on 9/9/08. The progress note of 7/16/08 does not address the infractions of 7/1, 7/6, 7/8, 7/10. The next progress note of E4 (where PRSC is to document) states "resident has been smoking in room lately. I took cigarettes away and told him if further smoking there would be consequences." There is no evidence that consequences progressed, or that the resident was supervised.	F9999		

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F9999	Continued From page 31 There was no evidence that smoking plan was followed on incidents of 8/5, 8/15 where resident was smoking in room and bathroom. Progress note of 8/25/08 addresses fact that again R12 was caught with pack of cigarettes and they were taken away. E4 then states, "I told him not to have someone go out and buy him a pack of cigarettes." The facility apparently was aware of how this resident was obtaining smoking material and did not investigate and actively address the issue of another resident purchasing the cigarettes as part of R12's overall plan. The care plan interventions were not updated, changed or individualized to attempt to curb this unsafe smoking. In addition, interviews with E3 and E4 substantiated that new interventions were not attempted and both were aware of the ongoing safety issue of continued smoking of R12. E4 denied knowing what the current smoking policy entailed or how additional infractions were to be handled, and what other suggested interventions were that could have been used for R12. E3 was also present in the room during the interview. During initial tour on 9/8/08 at 10:50 am, there were ashes around R12's bed and cigarette butts and ashes in the bathroom. There was a strong smell of fresh cigarette smoke in the bathroom. E9, staff monitoring the 2500 hallway came into the room and acknowledged that there was a strong smell of smoke and indicated that it was hard to identify the offender as all three residents in the room had been identified as unsafe smokers. This concern was also shared with E8, nurse, who was touring with surveyor. During tour, rooms with ashes, cigarette butts on floor and smell of cigarette smoke in the bathroom were noted in 2511, 2512, 2505 and 2502 with E8 present. E8, during the tour, informed the	F9999		

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F9999	Continued From page 32 social service staff about these concerns. Review of R12's chart and other charting such as 24 hour report showed no follow up was done on these concerns. Again, on 9/9/08 at 4:10 PM, R12 was noted coming out of his bathroom with cigarette smoke coming out of his nostrils. R12 had just flushed the butt into the toilet. R12 again denied he was smoking. R36 visiting the room at that time and confirmed that R12 was in the bathroom smoking while talking to him. R36 indicated on interview that R12 was still smoking when surveyor came into room but came out of bathroom right away and started denying what he was doing. The facility finally put R12 on a 1:1 supervision management after the Immediate Jeopardy was called on 9/9/08 indicating that R12 was an identified high risk smoker and that the facility staff consistently failed to follow their policy. The facility notified the physician on 9/9/08 who then ordered resident to be transferred to hospital for psychiatric evaluation. There was no previous indication of any change in behaviors other than smoking problems before R12 was transferred. 2. In the case of R18 who had 4 infractions in 3 months, surveyors reviewed the resident's record for the facility response to to her continued smoking since they had identified her as a high risk resident. Per E7, PRSC should counsel and document all smoking infractions somewhere in chart but primarily on blue social service notes. Review of R18's record shows multiple problems with behavior and drug seeking but the only reference to smoking was by E6 on 9/8 when she (R18) was counseled. Smoking was discovered	F9999		

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F9999	Continued From page 33 back on 9/2/08, so counseling was not done in a timely manner and did not address new approaches or alternatives to care plan goals which were not individualized or consistently implemented. Care Plan states: place on observation, remove smoking materials, explain consequences. This care plan was not consistently or timely implemented. 3. R5 who also was previously identified as a high risk smoker and was found smoking 5 times in 2 months. The progress record fails to note and address incidents of smoking in any PRSC note, and the last note was dated 7/10/08. 4. For R7, R29, R17, R8, R31, R32, R35 and R34 who also had multiple examples of inappropriate smoking, the medical documentation and notes by their PRSC and in the nursing notes also failed to show timely counseling and evidence that the facility updated plans of care and followed current smoking policy. 5. R8 was observed smoking in his room as documented on the 24 hour report dated July 4 and August 13, 2008. There were no interventions documented. Care plan and assessment document him as a safe smoker. There was no counseling and the resident was not considered as a non-compliant. 6. During initial tour on 9/8/08 at 10:50 am, there were cigarette butts and ashes in the bathroom of R17 and R16. There was a strong smell of fresh cigarette smoke in the bathroom. E9, the hallway monitor, indicated that she was aware of the situation as she caught the roommates smoking and had reported this. The 24 hour	F9999		

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F9999	Continued From page 34 report reflects that R16 was reported smoking in her bathroom at 6:25 am. On record review, there were no interventions and counseling documented. The care plan was not changed and last smoking assessment still considered R16 a safe smoker. E6, R16's PRSC was asked on 9/9/08 what intervention she had done for R16's and R17's incidents. E6 stated she was not aware of any problems and was not made aware of any problem. R17 was identified as a problem smoker. R17 was caught smoking in the room 7/27, 8/8, 8/13 and 9/3, as documented on 24 hour reports. The last progress note for PRSC was dated 6/27/08 and no intervention was documented on these incidents of unsafe smoking. Care plan reflects a goal to remain in smoking program and reduce incidents of smoking in room through next eval. Resident continues to be noncompliant and interventions have not been effective. 7. R7 was caught smoking in the bathroom 8/6/08 and 9/7/08 per 24 hour documentation. There was no documentation of interventions on these unsafe smoking practices. There is no care plan to assure safety of resident. While investigating an incident of cigarette smoke and ashes in R7's bathroom on 9/10/08, E7, assistant administrator, stated that R7 is not considered a problem as he is a safe smoker. 8. During initial tour with E8, the following rooms were noted with ashes and smell of cigarette smoke in their bathroom: Rooms 2511, 2512, 2505 and 2502. E8 was noted relaying the concern to social service who went to the identified rooms. There was no documentation of investigation or follow up to assure preventive	F9999		