Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007074	A. BUILDING: ______ B. WING ______	C 08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAVILION OF LOGAN SQUARE, THE	**2242 NORTH KEDZIE CHICAGO, IL 60647**

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S 000	Initial Comments Complaint Investigations: 2486004/IL00176182 Facility Reported Incidents of: 07/04/24/IL175523	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210a) 300.1210c) 300.1210d)6) 300.1220b)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as	S9999		

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S9999	Continued From page 1	S9999		

applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)
c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.
d) Pursuant to subsection (a), 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:
6) Developing and maintaining nursing service objectives, standards of nursing practice, written policies and procedures, and written job descriptions for each level of nursing personnel.

These Regulations were not met as evidenced by:

Based on observations, interviews, and record

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S9999	Continued From page 2	S9999		

review, the facility failed to a.) implement fall precaution interventions for two (R1, R3) residents, b.) provide adequate supervision and monitoring to prevent falls for two (R1, R2) residents, and c.) provide supervision and monitoring for four (R4, R5, R6, R7) residents during the designated smoking time to ensure residents practice safe smoking in the designated area. Theses failures resulted in R1 falling while in the facility on 07/06/2024 and sustaining a facial laceration. R1 experienced a subsequent fall while in the facility on 07/29/2024 and sustained a head contusion. R2 fell on 07/04/2024 while in the facility and sustained an iliac crest fracture of the pelvis.

Findings include:

On 08/10/2024 at 8:37AM, surveyor observes a yellow sticker outside of R1's room door next to her name. R1 observed inside of her room sitting up in high fowler's position with head of bed at 90 degrees eating her breakfast meal. R1 is not interviewable. Surveyor observes R1's bed in a high position, R1's bed observed to not be in the lowest position. R1's bed observed in a high position that reaches surveyor's mid lower thigh measuring approximately 2 feet, 2 inches in height.

On 08/10/2024 at 9:15AM, V6 (Certified Nursing Assistant/CNA) states the yellow sticker placed outside the resident's rooms next to their names indicates that the resident is at risk for falls.

On 08/10/2024 at 9:39AM, surveyor observes a yellow sticker outside of R3's room door next to her name. R3 observed sitting up in her bed in a semi-fowler's position with head of bed at 45 degrees.

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S9999	Continued From page 3	S9999		

R3's primary language is Spanish and R3 is not interviewable. Surveyor observes R3's bed in a high position, R3's bed observed to not be in the lowest position. R3's bed observed in a high position that reaches surveyor's mid upper thigh measuring approximately 2 feet, 5 inches in height.

On 08/10/2024 at 9:47AM, V8 (Certified Nursing Assistant/CNA) located inside of R3's room and surveyor makes V8 aware of R3's bed being in a high position. V8 observes R3's bed position and states R3's bed is not in the lowest position. V8 observed operating R3's bed and lowering R3's bed to the lowest position. R3's bed is now in a position that reaches the top of surveyor's calves measuring approximately 1 feet, 5 inches in height. V8 states with R3's bed being in a high position, R3 could have rolled out of bed, hit the floor, and fractured a bone in R3's body. R3 states she is the CNA responsible for caring for R3 but maybe the nurse came in to give R3 her medication and forgot to the lower R3's bed.
On 08/10/2024 at 1:52PM, V14 (LPN) states she was the 2nd shift oncoming nurse assigned to the second floor of the facility the day R1 fell on 07/29/2024. V14 states she did not witness R1's fall and was informed by V13 (LPN) during change of shift report that R1 had fallen in the dining room approximately 10 minutes before 3PM. V14 states when she arrived, V13 was already in the process of taking care of everything pertaining to R1's fall.

Nursing progress note dated 07/29/2024 at 3:27PM written by V13 (LPN) documents "Observed R1 in a right lide lying position in the dining room next to wheel chair. R1 poor historian. Observed R1 for injury. Hematoma

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S9999	Continued From page 4	S9999		

observed to Right side of forehead. Pillow placed under R1 head. 911 call placed. R1 able to move extremities spontaneously within normal limits for resident. Vitals taken 110/64, o2 94, and bloodsugar 120. The 911 paramedics arrived to facility and transferred R1 to hospital. Call placed to Daughter. No answer. Message left."

An attempt to contact V13 (LPN) was made on 08/10/2024 at 2:50PM, left voicemail, awaiting call back.

On 08/10/2024 at 2:51PM, V15 (Licensed Practical Nurse/LPN) states she was alerted by the Certified Nursing Assistant/CNA assigned to the dining room monitoring shift that R2 had fallen. V15 states she cannot recall which CNA informed her but she remembers it being a male CNA. V15 states the CNA informed her that R2 had fallen while in the dining room due to R2 pushing back in his chair and R2 fell backwards. V15 states R2's wheelchair was locked while R2 was sitting in it. V15 states R2 continued to push his wheelchair backwards against the locked wheelchair until he tilted backwards and fell. V15 states upon her assessment, it felt like R2 had a lump on the back of his head. V15 states she called the doctor and sent R2 out to the hospital to be evaluated. V15 states there were two CNAs inside the dining room during the time R2 fell. V15 states one CNA pressed the call light to call for assistance and the other CNA came to inform her of R2's fall.

Nursing progress note dated 07/04/2024 at 1:30PM, written by V15 (LPN) documents "R2 noted sitting in lock wheelchair while trying to push self backward, he tilted wheelchair over and hit back of head on floor. Full Body assessment perform, Noted with a small bump on head.

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S9999	Continued From page 5	S9999		

Denies pain or discomfort, No SOB, Vital signs stable. PERRLA noted, Lung sounds clear to auscultation. Abdomen soft and non-tender, Active Bowel sounds in all 4 quadrants. Active ROM on upper and lower extremities pt. tolerated well. Skin intact. Safety measures in place. Call light within reach to make needs known. Neruo Check Perform. N/P made aware of fall with order's to transfer resident to hospital for medical evaluation. POA (Daughter) made aware of fall. Will continue to monitor plan of care and document accordingly."

On 08/10/20204 at 3:22PM, V16 (LPN) states she was the nurse assigned to care for R1 the day R1 fell at the facility on 07/06/2024. V16 states she was performing medication administration to the residents when a CNA reported to V16 that R1 had fallen. V16 states the CNA reported to her that R1 got up out of the wheelchair and fell. V16 states she does not recall the name of the CNA who reported this to her. V16 states upon assessing R1, R1 had an open area to the forehead and R1 was bleeding. V16 states R1 had a gash in her forehead and she cleaned R1's wound. V16 states she then called the doctor and 911 and sent R1 out to be evaluated at the local hospital. Surveyor inquires to V16 the reason residents continue to fall in the dining room while being monitored by the CNA staff. V16 states she sees the CNAs in the dining room monitoring the residents. V16 states she does not have an answer to how residents continue to fall in the dining room despite being monitored by CNAs in the facility.

Nursing progress note dated 07/06/2024 at 6:46PM written by V16 (LPN) documents "Writer notified per CNA staff that R1 was observed on the floor, inside of dining room. Upon further

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S9999	Continued From page 6	S9999		

assessment, R1 was noted on the floor in supine position with acute hemorrhage to the L forehead. First aide rendered, in-house NP made aware, orders given to transfer resident via 911 to the nearest hospital. 911 initiated, and awaiting transport. ROM performed without pain/discomfort, writer remains at resident's side, awaiting transport of resident. VS: 98.0-82-130/66-97% R/A."

On 08/10/2024 at 3:46PM, V17 (R1's Friend) states she comes to visit the facility at least 3-4 times a week and observed R1's bruises on her face. V17 states another resident at the facility informed her that R1 fell inside of the dining room on two separate occasions. V17 states the other resident informed her that it was at least 3 CNAs in the dining room when R1 recently fell. V17 states she witnesses the staff members in the facility on their phones while monitoring the residents in the dining room. V17 states the facility staff are not able to properly monitor the residents due to them being on their phones even with their earpieces in their ears.

On 08/11/2024 at 9:45AM, V21 (Restorative Rehab Aide/CNA) located on the third floor of the facility inside of the dining room monitoring residents. V21 states she has been working at the facility since 1998. V21 states she works at the facility as a restorative rehab aide Monday through Friday and on the weekends (Saturday through Sunday) she works as a CNA at the facility. V21 states the CNA staff takes turns monitoring the dining room every thirty minutes to monitor the residents for falls, unsteady gait, and any resident altercations that may arise.

On 08/11/2024 at 9:57AM, surveyor located inside of the third floor dining room and observes

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S9999	Continued From page 7	S9999		

V21 inside of the dining room with a black bluetooth earpiece inside of her left ear.
CNA assignment sheet documents that V21 was assigned to monitor the third floor dining room from 9:30AM-10:00AM.

On 08/11/2024 at 11:31AM, V20 (CNA) states he was the CNA assigned to monitor the second floor dining room the day R2 fell on 07/04/2024. V20 states he noticed that R2 was agitated while R2 was sitting in the dining room. V20 states R2's wheelchair brakes were in the locked position. V20 states he saw R2 pushing against the table with his wheelchair brakes still locked and R2 fell backwards. V20 states he must have looked away for a second because he did not see R2 actually fall. V20 states when he turned back around, R2 was lying on the floor in the second floor dining room yelling out in Spanish. V20 states R2 yelled that he had fell and R2 called out for help. V20 states he was located in dining room when R2 fell but he was also walking around the dining room checking on other residents. V20 states he stayed with R2 while another CNA called the nurse for help.

CNA assignment sheet for the second floor of the facility dated 07/04/2024 documents that V20 (CNA) was responsible for monitoring the dining room during the date and time R2 fell in the dining room.

R2's Face sheet dated 08/10/2024, documents that R2 is an 94-year-old male with diagnoses not limited to: Cardiac arrhythmia, unspecified dementia, need for assistance with person al care, unsteadiness on feet, fracture of right ilium, repeated falls, atrial fibrillation, and osteoarthritis.

R2's MDS (Minimum Data Set) dated 07/11/2024,

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S9999	Continued From page 8	S9999		

documents that R2 has a BIMS (Brief Interview for Mental Status) of 04/15 indicating that R2 is severely cognitively impaired. R2's Activities of Daily Living (ADL) Assistance documents that R2 is dependent with sit-to-stand, and transfer. R2's MDS documents that R2 utilizes a manual wheelchair and the activity of walking 10 feet was not attempted due to R2's medical condition or safety concerns.

R2's hospital records dated 07/04/2024 documents that R2 was admitted to the hospital as a result of experiencing a fall while in the facility. R2 was diagnosed with a closed fracture of the right iliac crest.

R2's Fall Risk Assessment dated 07/10/2024 documents that R2 has a fall risk score of 16, indicating that R2 is at high risk for falls.

Per facility reported incident dated 07/04/2024, R2 sustained a fall which resulted in a closed fracture to R2s' iliac crest while at the facility on 07/04/2024.

On 08/11/2024 at 11:45AM, V20 (CNA) states he mainly works on the second floor of the facility. V20 states he remembers when R1 recently fell at the facility on 07/29/2024. V20 states it was towards the end of his shift when R1 fell in the dining room. V20 states R1 fell approximately a couple of minutes prior to the end of his shift. V20 states he was getting ready to leave since it was the end of his shift. V20 states the oncoming 2nd shift CNA staff had arrived to the second floor to relieve him so there was a lot of staff in the dining room during the time R1 fell. V20 states he cannot recall exactly who was located in the second floor dining room. V20 states he remembers at least three CNAs being present in

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S9999	Continued From page 9	S9999		

the second floor dining room when R1 fell. V20 states the facility CNA staff changes shifts at 3PM. Surveyor asks V20 who was responsible for monitoring the second floor dining room when R1 fell. V20 states he is not really sure and suggests that surveyor refer the question to management since other CNAs had arrived and clocked in for their shift a couple of minutes earlier that day. V20 states when R1 fell on 07/29/2024, R1 was sitting in a wheelchair closer to the back of the dining room near the TV. V20 states when he saw R1, R1 was lying on the floor.V20 states since he was in the dining room with his other co-workers, they also saw R1 lying on the floor. V20 states the nurse on duty came to assess R1 and V20 left the facility for the day.

CNA assignment sheet for the second floor of the facility dated 07/29/2024 documents that V20 (CNA) was responsible for monitoring the dining room during the date and time R1 fell in the dining room.
R1's Face sheet dated 08/10/2024, documents that R1 is an 60-year-old female with diagnoses not limited to: Cerebral infarction, contracture of right hand, unspecified fall, osteoarthritis of hips, hyperlipidemia, and atherosclerotic heart disease.

R1's MDS (Minimum Data Set) dated 06/06/2024, documents that R1 has a BIMS (Brief Interview for Mental Status) of 07/15 indicating that R1 is severely cognitively impaired. R1's Activities of Daily Living (ADL) Assistance documents that R1 requires substantial/maximal assistance with sit-to-stand and transfer. R1's MDS documents that R1 utilizes a manual wheelchair and the activity of walking 10 feet was refused by R1.

R1's care plan dated 07/24/2023 documents that R1 is care planned for risk for falls with

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S9999	Continued From page 10	S9999		

intervention that includes: "bed in low position."

R1's hospital records dated 07/29/2024 documents that R1 was evaluated at the local hospital as a result of experiencing a fall in the facility. R1 was diagnosed with a head contusion.

R1's hospital records dated 07/06/2024 documents that R1 was evaluated at the local hospital as a result of experiencing a fall in the facility. R1 was diagnosed with a facial laceration.

R1's Fall Risk Assessment dated 07/29/2024 document that R1 has a fall risk score of 16, indicating that R1 is at high risk for falls.

R3's Fall Risk Assessment dated 08/02/2024 documents that R3 has a fall risk score of 7, indicating that R3 is at moderate risk for falls.

R3's comprehensive care plan dated 08/02/2024 documents that R3 is care planned for risk for falls and is included in the "Falling Star Program."

On 08/11/2024 at 12:47 PM, V19 (LPN/Fall Coordinator) states she has been the fall coordinator at the facility for about 2 years. V19 states the fall risk program includes the residents who have the yellow stickers on their room doors. V19 states this is done to make sure residents have measures in place to try and prevent falls. V19 states she is made aware of resident's falls by the nursing staff, the DON (Director of Nursing) , and other staff members calling or texting her to inform her. V19 states she was informed that R1's fall on 07/06/2024 was due to R1 attempting to get up from her chair and R1 fell. V19 states she cannot recall if R1 had stitches to her forehead, but V19 remembers that R1 had steri strips on her forehead. V19 states

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S9999	Continued From page 11	S9999		

R1 is able to say little words at a time and is able to make her needs known, V19 states she can understand R1. V19 states R1 informed V19 that R1's fall on 07/29/2024 was due to R1 trying to reposition herself in the wheelchair. V19 states R1 fell and was found in a right side lying position in the dining room due to R1 trying to reposition herself.

On 08/11/2024 at 2:25PM, V1 (Administrator) states she went to visit R1 after R1 fell on 07/06/2024. V1 states R1 informed her that R1 was trying to get up out of her wheelchair when she fell. V1 states she reviewed the camera footage and saw that a CNA was located in the dining room with R1 when R1 fell on 07/06/2024 but the CNA could not reach R1 in time. V1 states R1 was evaluated by the wound care team when R1 returned from the hospital and R1 did not have any stitches. V1 states R1 only had bruises on her face. V1 states when R1 fell the second time on 07/29/24, R1 was trying to reposition herself and fell over on her side.
V1 states she has received complaints about the staff members being on their phones while monitoring residents in the facility. V1 states she received a complaint approximately one week ago about staff being on their phones. V1 states she has witnessed staff members on their phones at times while working in the facility. V1 states she has even reviewed the camera footage and seen some staff members on their phones while working in the facility. V1 states she addresses it right away and brings this to the staff's attention and tells them to get off of their phones. V1 states she discusses with the staff about how being on their phones can cause distractions and that staff needs to be more involved and keep residents in their line of vision while in the dining rooms. V1 states that employees should not be utilizing their

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(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) COMPLETE DATE
S9999	Continued From page 12	S9999		

phones and earpieces should not be in staff member's ears because it is not appropriate. V1 states she explains to the staff that they cannot fully care for the residents when they are distracted by their phones and that it is also a dignity issue for the residents. V1 states when R1 fell on 07/04/2024, she reviewed the camera footage and saw that a CNA had just wheeled R2 into the dining room and placed him at the table. V1 states R2's brakes were locked on his chair and R2 pushed himself backwards and fell. V1 states R2 grabbed the table and used all his strength and pushed himself backwards. Surveyor inquires to administrator of the reason why residents continue to fall in the dining room while being monitored by staff. V1 states most of the residents are diagnosed with dementia and their behaviors are often so unpredictable. V1 states upon hire, every employee is given the employee handbook in the facility. V1 states the staff receives the handbook electronically and each staff members signs electronically indicating that they have read and understand the employee handbook.

Facility Employee Handbook dated 06/01/2024 Page 39 documents in part, "personal calls and messages should not be answered during work time."
R1's skin assessment dated 07/18/2024 documents that R1 had bruising to her right eye that was identified on 07/07/2024.

Facility policy dated 05/2015, titled "Falls-Clinical Protocol" documents in part, "Treatment/Management: 1. Based on preceding assessment, he staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007074	A. BUILDING: ______ B. WING ______	C 08/12/2024

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S9999	Continued From page 13	S9999		

Facility policy dated 05/2015, titled "Fall Management" documents in part, "Policy statement: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. 4. For residents who have been identified at risk for falls upon admission, a care plan shall be developed which includes the resident and/or his/her family input for interventions that have or have not worked in the past. Additional interventions will be developed to promote a safe environment. The resident's individual needs for staff assistance will be assessed. Then the resident will be placed on the fall prevention program."

On 08/10/2024 at 9:59AM, surveyor located on the 1st floor of the facility and observes V10 (Activity Aide) inside of the 1st floor dining room with several residents located in the dining room. Surveyor also observes an opened glass door that leads to the first floor patio adjacent to the 1st floor dining room. Surveyor observes five residents on the patio smoking and not being supervised by staff members. V10 states she is currently responsible for monitoring the residents who are smoking outside on the patio and she is responsible for monitoring the residents inside the dining room for activities and hydration.

On 08/10/2024 at 10:01AM, surveyor and V10 now located outside on the 1st floor smoking patio. R4 enters the 1st floor smoking patio with two cigarettes (one behind his left ear and one in his hand) and a light green cigarette lighter in his possession. R4 observed lighting his own cigarette, places the lighter in his pocket, and begins to smoke his cigarette. Surveyor makes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 14	S9999		

Continued From page 14

V10 aware of this observation and inquires to V10 about the protocol for smoking and safe smoking practices. V10 states she also observed R4 and R4 is not allowed to possess his own smoking materials and all smoking materials should be kept by the facility. V10 is now observed asking R4 to give her possession of the light green lighter that R4 placed inside of his pocket. V10 states R4 resides on the third floor of the facility so she is not sure how R4 got possession of his own smoking materials. V10 suggest that sometimes R4's family comes to visit him in the facility and brings R4 items and maybe R4's family brought cigarettes for R4 and did not tell anyone in the facility. V10 states there is potential that a resident can start a fire, get burned, and hurt themselves if a resident who is not allowed to possess their own smoking materials gets access to smoking materials.

On 08/10/2024 at 10:13AM, V10 observed exiting the 1st floor dining room and leaving the smoking bin unlocked and unattended. Surveyor observes the blue, transparent, plastic bin labeled 5.92 quarts with cigarettes and lighters inside of the blue bin. Blue bin has a plastic cover on it and is observed left on a table inside of the 1st floor dining room with several residents observed sitting down in the first floor dining room. V10 enters the dining room and surveyor makes V10 aware of the smoking bin being left unlocked and unattended. V10 then states a resident could have potentially grabbed the bin and obtained access to the smoking materials.

On 08/10/2024 at 10:15AM, V11 observed on the first floor smoking patio sitting in a chair. V11 states she is responsible for monitoring the residents who are smoking. V11 states she was not initially outside on the first floor smoking patio

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S9999		S9999		

Continued From page 15

monitoring the residents during their smoke break because she was located on another floor of the facility performing showers for the residents. V11 states that there should be someone outside with the residents at all times to monitor them while they are smoking.

On 08/10/2024 at 10:22AM, surveyor located on the first floor nurses station and observes the blue smoking bin behind the nurses station on the counter unlocked and unattended. V9 (Registered Nurse/RN) now located at the 1st floor nurses station and observes the blue smoking bin. V9 takes the blue lid off of the smoking bin and acknowledges that the smoking bin is unlocked and was not attended by anyone. V9 states a resident could have taken the cigarettes, began smoking them, and they could have started a fire. V9 states the smoking bin should not be left unlocked and unattended.

On 08/10/2024 at 12:10PM, V12 (Social Services Director) states each social worker assigned to a floor is responsible for completing their own smoking assessment for the residents. V12 states the smoking assessments should be performed quarterly and annually, or if with a change in condition. The smoking assessment should include the designated areas to smoke, if the resident is a safe smoker, if the resident is allowed to have their own smoking materials and light their own cigarette, and if they need an apron to prevent smoking hazards. V12 states the staff members in the activities department are responsible for dispersing the resident's smoking materials and lighting their cigarettes. V12 states if a staff member notices that a resident is in possession of smoking materials, then they have to confiscate it immediately. V12 states then the social services staff educate the resident and

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S9999	Continued From page 16	S9999		

explain the risks involved with handling their own smoking materials. V12 states R4 is not allowed to have possession of his own smoking materials or lighter. V12 states if R4 is in possession of his own smoking materials and lighter, then R4 could potentially smoke at undesignated times and in undesignated places in the facility. V12 states this could potentially cause a fire in the facility and residents could be injured. V12 states this could also cause an explosion if R4 smokes around residents with oxygen tanks.

On 08/10/2024 at 12:20PM, surveyor and V12 reviews R4's smoking risk assessment dated 07/31/2024 and V12 states R4 is supposed to have a smoking risk score. V12 states she does not see a smoking risk score on R4's assessment. V12 states R4's smoking risk assessment does not provide the required information to be included in a smoking risk assessment. V12 states since the information is missing, then R4's smoking risk assessment dated 07/31/2024 is not complete and is not accurate. V12 states the purpose of the smoking risk assessment is to provide full detailed information about resident's smoking abilities, their risk score, where they can smoke, and if they can have their own smoking materials.

R4's care plan dated 07/31/2024 documents in part, "R4 is a smoker. He has been educated on the negative consequences of continued smoking due to his medical condition. R4 will not smoke without supervision through the review date. R4 will not suffer injury from unsafe smoking practices through the review date. Educate R4 about smoking risks and hazards and about smoking cessation aids that are available. Instruct R4 about the facility policy on smoking: locations, times, and safety concerns. R4

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S9999	Continued From page 17	S9999		

requires SUPERVISION while smoking. Notify the charge nurse immediately if it is suspected R4 has violated facility's smoking policy."

R4's smoking risk assessment dated 07/31/2024 only documents that R4 smokes tobacco.
On 08/11/2024 at 10:10AM, V10 (Activity Aide) observed standing on the first floor patio while residents smoke.

On 08/11/2024 at 10:08AM, V10 walks inside of the facility and away from the smoking patio. R5 then observed with a cigarette in her hand and R5 walks up to R6 while R6 is smoking his own cigarette and R5 is observed lighting her cigarette from R6's prelit cigarette.

On 08/11/2024 at 10:10AM, V18 (CNA) walks onto the first floor patio and states that she will now be monitoring the first floor patio. On 08/11/2024 at 10:17AM, while V18 is outside on the first floor smpking patio, R6 then observed with a cigarette in his hand and R6 walks up to R7 while R7 is smoking his own cigarette and R6 is observed lighting his cigarette from R7's prelit cigarette. V18 states residents are not supposed to light their cigarettes with another resident's cigarette because it can cause a fire.

On 08/11/2024 at 10:25AM, V10 states R7 smokes but R7 is blind and unable to see and V10 has explained to R5 and R6 that they are not allowed to light their own cigarettes from another resident's cigarette.

On 08/11/2024 at 9:51AM, surveyor located on the third floor of the facility and observes that five resident rooms have signs on their doors labeled "Oxygen in use."

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S9999	Continued From page 18 Facility policy, dated 11/09/2023, titled "Smoking Policy" documents in part, "Policy: ....All residents smoking materials will be kept by the facility. Purpose: To provide a healthy and smoke safe environment for all residents, employees and visitors.7. All residents will be under supervision while smoking. A. Smoking monitors will hold lighters for ignition of cigarettes. 8. Smoking material will be kept under facility staff control. Residents are not allowed to have any smoking materials in their possession. This includes lighters, cigarettes, cigars, loose tobacco, rolling papers, chewing tobacco, pipes, and loose pipe tobacco." (B)	S9999		