

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009856	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/09/2017
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NAME OF PROVIDER OR SUPPLIER WENTWORTH REHAB & HCC	STREET ADDRESS, CITY, STATE, ZIP CODE 201 WEST 69TH STREET CHICAGO, IL 60621
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S 000	Initial Comments Complaint Investigation 1780680/IL91538 Incident Report Investigation IRI of 1-01-17/IL91094	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210d)2,3,6 300.1220b)3 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall 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 resident care plan. 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. 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: 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and	S9999	<p>Attachment A Statement of Licensure Violations</p>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE 03/03/17
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S9999	<p>Continued From page 1</p> <p>emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.</p> <p>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.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>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. 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 reviewed at least every three months.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These requirements were not met as evidenced by:</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>Based on observation, interview and record review the facility failed to provide immediate emergency care for a resident with a change of condition, failed to develop a care plan for unsafe smoking for a resident, failed to report a resident's elevated blood glucose level and resident's refusal of scheduled insulin to the physician and failed to implement care plan interventions for a resident with diabetes. This refers to 2 of 18 residents (R1, R11) reviewed for nursing home services in a sample of 18.</p> <p>This failure resulted in delayed assessment and care of R1 following a facility fire which led to R1's death.</p> <p>Findings Include:</p> <p>1. R1's face sheet indicates that he was admitted to the facility on 10/21/16. R1's face sheet diagnoses include chronic obstructive pulmonary disease, dependence on supplemental oxygen, major depressive disorder, cocaine use and schizophrenia.</p> <p>R1's Minimum Data Set (MDS) dated 10/31/16 indicates that R1 had a Brief Interview for Mental Status score of 15, indicating no cognitive deficit.</p> <p>R1's smoking agreement dated 10/21/16 indicates that R1 was not a smoker at the time of admission.</p> <p>The facility's initial incident/accident/allegation notification dated 1/1/17 and filed 1/9/17 indicates that R1 was observed in the hall with some smoke noted in his room. The facility's report dated 1/6/17 indicates that R1 was taken to a local hospital and subsequently expired. The report also indicates that the police detective and</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>investigator gave a report that the fire was accidental with an unknown origin.</p> <p>R1's death certificate dated 1/1/17 indicates that R1's cause of death was thermal injury and careless use of smoking materials while on home oxygen therapy.</p> <p>On 1/18/17 at 12:12 pm E6 (nurse aide) stated that on 1/1/17 in the 9:00am hour she was standing at the hall kiosk charting and saw R1 sitting between the beds. E6 stated that the fire alarm sounded and R1 wheeled himself into the hallway in his motorized wheelchair. E6 stated that R1 had his oxygen via nasal cannula in his nares and was receiving oxygen. E6 stated that R1 did not say anything but was observed having a difficult time breathing. E6 stated that when she approached R1 she noticed that the end of R1's mattress was on fire. E6 stated that the fire on R1's mattress was small like a fire on a stove. E6 stated that R1's oxygen concentrator near the head of the bed was also burned from fire. E6 stated that she proceeded to move R1 further down the hall and grabbed the fire extinguisher to put the fire out. E6 stated that once the fire was out she put the extinguisher down and proceeded to continue down the hall with R1 (wheelchair bound). E6 stated that she noticed that the fire re-ignited and stopped to extinguish the flames. E6 stated that once the fire was out she proceeded down the hall again with R1 but she noticed the fire had re-ignited again and stopped to re-extinguish the fire, finally putting it out permanently. E6 stated that she did not yell code red or fire because she did not want to cause everyone to panic. E6 stated that E9, Social Services took over pushing R1 to the nursing station to E11 Licensed Practical Nurse (LPN). E6 stated that she received staff assistance from</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>E10 (CNA) after coming through the fire doors and staff noticed the smoke coming from west corridor. E6 stated that she did not close the door to R1's room during the fire. E6 stated that she believes that she closed all room doors after extinguishing the fire and getting R1 to the nursing station.</p> <p>On 1/26/17 at 9:21am the surveyor with Z4 (Arson Unit Detective) facility videotape footage was reviewed with a date of 1/1/17 starting at 9:50 am. The videotape shows the fire doors to the southwest corridor closing at 9:52 am. The videotape shows E11 Licensed Practical Nurse (LPN) sitting at the nurse's station when the fire doors closed. At 9:53 am E11 was observed to take a sip of her drink, stand, walk over to the medication carts and place the medication carts behind the nursing station. E11 was then observed sitting back down at the nurse's station to continue her drink. E11 was not observed leaving the nursing station to assist during the fire alarm. At 9:54 am E6 CNA and E9 are observed bringing R1 through the double doors. R1 was observed to be slumped over the right side of the wheelchair, with no movement observed. E11 LPN walked over to R1 and took a quick glance at R1 and walked away to stand behind the nursing station. At 9:55 am E11 walked back over to R1 and placed the nasal cannula on R1. The nasal cannula was observed to be already connected to the oxygen tank on R1's wheelchair. E11 was not observed taking vital signs or performing an assessment on R1 between 9:54am (R1's arrival at the nurse's station) and 9:57 am (R1 was moved out of camera range). Facility staff was observed evacuating residents to the dining room from the 1st floor west hall between 9:54 am and 9:59 am. The videotape from another view near R1's room shows R1</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>wheeled himself out of the room in the motorized wheelchair with oxygen tubing attached to the oxygen tank trailing behind the wheelchair on the floor. R1 was observed sitting in an upright position in the wheelchair. E6 CNA was observed running towards R1 and then running back to get the fire extinguisher. R1 was observed sitting in the hall next to the south side of the wall (while E6 was observed running in and out of camera range with the fire extinguisher) gasping for air as the corridor filled with smoke.</p> <p>Z4 stated that R1 had burn marks on his face that were consistent with the oxygen tubing going around his ear. Z4 stated that there was a lighter and two cigarette butts found. Z4 stated that two oxygen tubings were observed, one in R1's room on the dresser and one coming from the oxygen tank on the wheelchair. Z4 stated that both oxygen tubings were burned. Z4 stated that R1's oxygen machine near the head of the bed was burned as well as a section on the side of the mattress, near the bottom.</p> <p>On 1/26/17 at 1:29 pm E3 Director of Nursing (DON) stated that if a resident has a change in condition they should be assessed and vital signs taken as soon as the change in condition is noted.</p> <p>On 1/26/17 at 4:00pm with E15 (Regional Administrator) videotape footage was reviewed on 1/1/17 during the fire. E11 LPN was not observed providing immediate emergency care to R1 after being brought to the nursing station by E6 CNA and E9 Social Services. E11 was observed applying an oxygen mask to R1 at 9:59 am, although E6 CNA reported that R1 was having a hard time breathing when she brought him to the nurse's station. Videotape footage</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>indicates that R1 was brought to the nurse's station at 9:54 am.</p> <p>On 1/27/17 at 9:19 am Z6 Fire Marshal stated that the fire involving R1 was caused by the ignition of oxygen tank due to smoking while wearing oxygen. Z6 stated that the facility staff nurses informed him that R1 was a smoker.</p> <p>On 1/18/17 at 2:01 pm E10 CNA stated that on 1/1/17 during the fire she (E10) noticed smoke coming from the hall when E6 CNA came through the fire doors with R1 and E9 (social Services). E10 stated that after noticing the smoke she (E10) went down the hall where the smoke was to assist E6 in making sure all residents were safe.</p> <p>On 1/18/17 at 2:30 pm E11 LPN stated that she received R1 in the wheelchair after E9 Social Services pushed R1 to the nursing station. E11 stated that R1's respirations were deep and shallow, so she placed oxygen on R1. E11 stated that the paramedics arrived immediately and took over care for R1.</p> <p>R1's social services note dated 1/1/17 at 11:46 am indicates: social services assisted escorting R1 to the nursing station and noticed that R1's hair, right ear and face were singed; the police were in the facility and requested that an ambulance be dispatched; while waiting on the ambulance the fire department and nursing were performing Cardiopulmonary resuscitation; the emergency medical technicians (EMT) escorted R1 into the ambulance; EMT returned into the facility and reported that R1 expired in the ambulance.</p> <p>On 1/26/17 at 4:00pm with E15 (Regional Administrator) videotape footage was reviewed</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>on 1/1/17 during the fire. E11 (Nurse-LPN) was not observed providing immediate emergency care to R1 after being brought to the nursing station by E6 CNA and E9 Social Services. E11 was observed applying an oxygen mask to R1 at 9:59 am, although E6 CNA reported that R1 was having a hard time breathing when she brought him to the nurse's station. Videotape footage indicates that R1 was brought to the nurse's station at 9:54 am. R1 was observed receiving CPR from the paramedics with the assistance on E6 (CNA). E11 (LPN) was not observed providing CPR to R1.</p> <p>R1's records do not include documentation of a complete assessment, with vitals upon R1's change of condition. R1's nurse's note dated 1/1/17 at 9:45 am indicates: R1 was non-verbal, breathing was deep and labored, oxygen via non re-breather mask was immediately placed on R1; paramedic was assessing R1, pulse was not palpable and vitals were not attainable; resident immediately placed on flat surface by paramedic and nursing staff; respiratory rescue bag and cardiopulmonary resuscitation was initiated; fire department intubated R1 and took R1 from the facility.</p> <p>The facility's job description for Staff Nurse (Registered Nurse/Licensed Practical Nurse) dated 1/2015 under essential functions indicates that staff nurses should administer professional services such as: ...care of the dead/dying, etc. as required; take and record temperature, pulse, respirations, blood pressure, accuchecks, etc. as necessary. The facility could not provide evidence that these functions were performed related to R1's fire related incident.</p> <p>The city fire department incident record dated</p>	S9999		
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S9999	<p>Continued From page 8</p> <p>1/1/17 under findings indicates that the fire department paramedics were dispatched at 9:57 am, and arrived at R1 at 10:05 am. The city fire department incident report indicates that R1 was unresponsive with no spontaneous respirations, no carotid pulse and dead on arrival to the hospital. The fire department report also indicates that R1 was possibly smoking in his room with oxygen on and the bed caught fire. R1 suffered burns to his hair.</p> <p>R1's emergency room records dated 1/1/17 under initial comments indicates the following: R1 was brought in by the fire department for pronouncement; evidently R1 was found dead in his nursing home bed; prior to dying, he had reportedly been smoking in the bed and accidentally lit his bed on fire. R1's emergency room records indicate that R1 was dead on arrival from the facility.</p> <p>On 1/17/17 at 2:57 pm E9, Social Service Director stated that R1's unsafe smoking behaviors were discussed in a care plan meeting as a behavior from past facilities. E9 stated that she was not made aware of any unsafe smoking behaviors exhibited by R1 while in the facility.</p> <p>On 1/19/17 at 9:12 am E1 (Administrator) stated that R1 was not care planned for unsafe smoking with oxygen because it was a behavior at a past facility.</p> <p>R1's behavior note dated 12/26/16 indicates, "Please monitor R1, he has tried on numerous occasions to smoke in the day room, he tries to go into other residents rooms." R1's behavioral note does not include what interventions were put in place to address R1's unsafe smoking behaviors and what actions were taken to ensure</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>that R1 did not have additional smoking materials in his possession. The facility could not provide documented evidence that R1's unsafe behaviors were communicated to other staff.</p> <p>On 1/18/17 at 11:15 R6 stated that R1 was frequently seen on the smoking patio with his oxygen on smoking a cigarette. R6 stated that on 12/24/16 she observed R1 on the smoking patio with his oxygen on and yelled at him to go back into the facility before he blows everyone up. R6 stated that on 12/25/16 or 12/26/16 R1 was observed smoking in the dining room while wearing oxygen. R6 stated that she informed E12 Assistant Director of Nursing (ADON) of R1's smoking while wearing oxygen. E12 ADON was not available for interview during this investigation. R6 stated that she also informed R1's family that R1 had been smoking with oxygen in place.</p> <p>On 1/18/17 at 3:34 pm Z2 (R1's Family) stated that her family was informed by another resident (name unknown) that R1 had been smoking with oxygen in place. Z2 stated that R1's family approached a male nurse to inquire about how R1 got the cigarettes and the lighter to smoke. Z2 stated that they were told that the matter was under investigation. Z2 could not recall who the male nurse was that stated that matter was under investigation. The facility could not provide documentation to indicate an investigation was conducted related to R1 smoking with oxygen in place.</p> <p>On 1/26/17 at 11:20 am Z5 (Veteran's Administration Social Worker) stated that R1 was on her caseload. Z5 stated that she met with the E9 (social services) and E13 (Assistant Director of Nursing) along with other members of the</p>	S9999		

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S9999	<p>Continued From page 10</p> <p>interdisciplinary team on 12/15/16 to discuss R1's behaviors. Z5 stated that R1's behavior of smoking with oxygen was discussed as a behavior from previous nursing facilities but was not discussed as a current issue for R1. Z5 stated that she was informed that R1 was not a smoker. Z5 stated that it was documented that R1 tried to harm himself with a knife and was sent out for evaluation and sent back to the facility after 24 hours observation. Z5 stated that the facility did not provide appropriate monitoring when R1 was re-admitted following the attempt to harm himself.</p> <p>R1's care plan does not include smoking with oxygen as a behavior, although R1 was observed with smoking materials while wearing oxygen.</p> <p>The facility's job description for Staff Nurse (Registered Nurse/Licensed Practical Nurse) dated 1/2015 under essential functions indicates that the staff nurse should assist in developing a written plan of care for each customer that identifies the problem/needs of the customer; report all concerns, complaints made by the customer or their family to the Administrator; fill out complete accident/incident reports. The facility could not provide evidence that these functions were performed related to R1's unsafe smoking practices.</p> <p>2. R11's face sheet diagnosis includes diabetes mellitus type 2.</p> <p>R11's Physician Order Sheet (POS) includes an order dated 5/19/15 for blood glucose monitoring: call Doctor for results less than 60 or greater than 400 before meals related to diabetes.</p>	S9999		
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S9999	<p>Continued From page 11</p> <p>R11's potential for hypo/hyperglycemic reaction care plan dated 10/07/13 with a goal target date of 3/7/17 interventions include report results that are outside of ordered parameters to Physician.</p> <p>R11's refusal to take medication care plan dated 5/29/14 with a goal target date of 3/7/17 interventions include review with R11 the consequences of treatment non-compliance.</p> <p>R11's weights and vital signs summary indicates that on 1/19/17 at 8:48 am R11 had blood glucose results of 428mg/dl.</p> <p>R11's January 2017 MAR indicates that on 1/19/17 at 8:00am R11 refused her scheduled dose of Humalog insulin solution 6 units subcutaneously one time a day related to type 2 diabetes.</p> <p>R11's nurses note do not include documentation for Physician notification for elevated blood glucose levels or what care plan interventions were in place related to the blood glucose result greater than 400mg/dl.</p> <p>Z3, Nurse Practitioner stated that the expectation of the staff is to follow the Physician orders to notify the Physician if glucose levels are below 60mg/dl or above 400mg/dl.</p> <p>R11's hospital records indicate that on 1/27/16 at 4:30 am R11's blood glucose level measured greater than 500mg/dl, normal reference range 76 - 120mg/dl. R11's hospital records indicate that R11 was admitted with diabetic ketoacidosis and acute kidney injury related to dehydration.</p> <p>The facility's change of condition American Medical Directors Association (AMDA) guidelines</p>	S9999		
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S9999	<p>Continued From page 12</p> <p>for reporting (2011) indicates that blood glucose levels greater than 300 mg/dl or less than 70 mg/dl (diabetic) should be reported immediately.</p> <p style="text-align: center;">(A)</p> <p>300.610a) 300.670a) 300.670c)1,2,3 300.670d) 300.1210b) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>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.</p> <p>Section 300.670 Disaster Preparedness</p> <p>a) For the purpose of this Section only, "disaster" means an occurrence, as a result of a natural force or mechanical failure such as water, wind or fire, or a lack of essential resources such as electrical power, that poses a threat to the safety and welfare of residents, personnel, and others</p>	S9999		

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S9999	<p>Continued From page 13</p> <p>present in the facility</p> <p>c) Fire drills shall be held at least quarterly for each shift of facility personnel. Disaster drills for other than fire shall be held twice annually for each shift of facility personnel. Drills shall be held under varied conditions to:</p> <ol style="list-style-type: none"> 1) Ensure that all personnel on all shifts are trained to perform assigned tasks; 2) Ensure that all personnel on all shifts are familiar with the use of the fire-fighting equipment in the facility; and 3) Evaluate the effectiveness of disaster plans and procedures. <p>d) Fire drills shall include simulation of the evacuation of residents to safe areas during at least one drill each year on each shift.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>b) The facility shall 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 resident care plan. 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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These Requirements are not met as evidenced by:</p>	S9999		
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S9999	<p>Continued From page 14</p> <p>Based on observation, interview and record review the facility failed to follow facility policy pertaining to rescue and removal of a resident from harm during a fire, staff immediate announcement and response to a fire alarm to prevent resident's injury and immediate assessment of a resident's injury due to fire and smoke inhalation. This applies to one resident (R1) out of 7 reviewed for fire safety and has the potential affect all 49 residents residing on the facility's first floor according to the facility's resident roster on 1/01/2017.</p> <p>Findings Include:</p> <p>The facility's initial incident/accident/allegation notification dated 1/1/17 and filed 1/9/17 indicates that R1 was observed in the hall with some smoke noted in his room. The facility's report dated 1/6/17 indicates that R1 was taken to a local hospital and subsequently expired. R1's death certificate dated 1/1/17 indicates that R1's cause of death was thermal injury and careless use of smoking materials while on home oxygen therapy.</p> <p>R1 was admitted to the facility on 10/21/16. R1's smoking agreement dated 10/21/16 indicates that R1 was not a smoker at the time of admission. R1's social services care plan conference dated 12/15/16 indicates that during previous placement R1 had behaviors of smoking with oxygen.</p> <p>On 1/18/17 at 12:12 pm E6 (nurse aide) stated that on 1/1/17 in the 9:00am hour she was standing at the hall kiosk charting and saw R1 sitting between the beds. E6 stated that the fire alarm sounded and R1 wheeled himself into the hallway in his motorized wheelchair. E6 stated that R1 had his oxygen via nasal cannula in his</p>	S9999		

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S9999	<p>Continued From page 15</p> <p>nares and was receiving oxygen. E6 stated that R1 did not say anything but was observed having a difficult time breathing. E6 stated that when she approached R1 she noticed that the end of R1's mattress was on fire. E6 stated that the fire on R1's mattress was small like a fire on a stove. E6 stated that R1's oxygen concentrator near the head of the bed was also burned from fire.</p> <p>E6 stated that she proceeded to move R1 further down the hall and grabbed the fire extinguisher to put the fire out. E6 stated that once the fire was out she put the extinguisher down and proceeded to continue down the hall with R1 (wheelchair bound). E6 stated that she noticed that the fire re-ignited and stopped to extinguish the flames. E6 stated that once the fire was out she proceeded down the hall again with R1, but she noticed the fire had re-ignited again and stopped to re-extinguish the fire, finally putting it out permanently. E6 stated that she did not yell code red or fire because she did not want to cause everyone to panic. E6 stated that E9 Social Services took over pushing R1 to the nursing station to E11 Licensed Practical Nurse (LPN). E6 stated that she received staff assistance from E10 (CNA) after coming through the fire doors and staff noticed the smoke coming from west corridor. E6 stated that she did not close the door to R1's room during the fire. E6 stated that she believes that she closed all room doors after extinguishing the fire and getting R1 to the nursing station.</p> <p>On 1/26/17 at 9:21am the surveyor with Z4 (Arson Unit Detective) facility videotape footage was reviewed with a date of 1/1/17 starting at 9:50 am. The videotape shows the fire doors to the southwest corridor closing at 9:52 am. The videotape shows E11 Licensed Practical Nurse</p>	S9999		

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S9999	<p>Continued From page 16</p> <p>(LPN) sitting at the nurse's station when the fire doors closed. At 9:53 am E11 was observed to take a sip of her drink, stand, walk over to the medication carts and place the medication carts behind the nursing station. E11 was then observed sitting back down at the nurse's station to continue her drink. E11 was not observed leaving the nursing station to assist during the fire alarm. At 9:54 am E6 CNA and E9 are observed bringing R1 through the double doors. R1 was observed to be slumped over the right side of the wheelchair, with no movement observed from R1. E11 LPN walked over to R1 and took a quick glance at R1 and walked away to stand behind the nursing station. At 9:55 am E11 walked back over to R1 and placed the nasal cannula on R1. The nasal cannula was observed to be already connected to the oxygen tank on R1's wheelchair. E11 was not observed taking vital signs or performing an assessment on R1 between 9:54am (R1's arrival at the nurse's station) and 9:57 am (R1 was moved out of camera range). Facility staff was observed evacuating residents to the dining room from the 1st floor west hall between 9:54 am and 9:59 am. The videotape from another view near R1's room shows R1 wheeled himself out of the room in the motorized wheelchair with oxygen tubing attached to the oxygen tank trailing behind the wheelchair on the floor. R1 was observed sitting in an upright position in the wheelchair. E6 CNA was observed running towards R1 and then running back to get the fire extinguisher. R1 was observed sitting in the hall next to the south side of the wall (while E6 was observed running in and out of camera range with the fire extinguisher) gasping for air as the corridor filled with smoke. Z4 stated that R1 had burn marks on his face that were consistent with the oxygen tubing going around his ear. Z4 stated that there was a lighter</p>	S9999		
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S9999	<p>Continued From page 17</p> <p>and two cigarette butts found. Z4 stated that two oxygen tubings were observed, one in R1's room on the dresser and one coming from the oxygen tank on the wheelchair. Z4 stated that both oxygen tubings were burned. Z4 stated that R1's oxygen machine near the head of the bed was burned, as well as a section on the side of the mattress near the bottom.</p> <p>On 1/26/17 at 1:29 pm E3 Director of Nursing (DON) stated that if a resident has a change in condition they should be assessed and vital signs taken as soon as the change in condition is noted.</p> <p>On 1/26/17 at 4:00pm with E15 (Regional Administrator) videotape footage was reviewed on 1/1/17 during the fire. E11 LPN was not observed providing immediate emergency care to R1 after being brought to the nursing station by E6 CNA and E9 Social Services. E11 was observed applying an oxygen mask to R1 at 9:59 am, although E6 CNA reported that R1 was having a hard time breathing when she brought him to the nurse's station. Videotape footage indicates that R1 was brought to the nurse's station at 9:54 am.</p> <p>On 1/27/17 at 9:19 am Z6 Fire Marshal stated that the fire involving R1 was caused by the ignition of oxygen tank due to smoking while wearing oxygen. Z6 stated that the facility staff nurses informed him that R1 was a smoker.</p> <p>On 1/18/17 at 2:01 pm E10 CNA stated that on 1/1/17 during the fire she (E10) noticed smoke coming from the hall when E6 CNA came through the fire doors with R1 and E9 (social Services). E10 stated that after noticing the smoke she (E10) went down the hall where the smoke was to</p>	S9999		

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S9999	<p>Continued From page 18</p> <p>assist E6 in making sure all residents were safe.</p> <p>On 1/18/17 at 2:30 pm E11 LPN stated that she received R1 in the wheelchair after E9 Social Services pushed R1 to the nursing station. E11 stated that R1's respirations were deep and shallow, so she placed oxygen on R1. E11 stated that the paramedics arrived immediately and took over care for R1.</p> <p>R1's social services note dated 1/1/17 at 11:46 am indicates: social services assisted escorting R1 to the nursing station and noticed that R1's hair, right ear and face were singed; the police were in the facility and requested that an ambulance be dispatched; while waiting on the ambulance the fire department and nursing were performing Cardiopulmonary resuscitation; the emergency medical technicians (EMT) escorted R1 into the ambulance; EMT returned into the facility and reported that R1 expired in the ambulance.</p> <p>E19's (Security Officer) investigation report (undated) indicates that when the alarm went off E19 quickly went to the panel to see the location and paged code red 3 times (code red first floor west 3 times). E19's statement indicates that he was looking at the cameras to see where everyone was and saw staff moving residents from their rooms on all floors. E19's statement indicates that R1 was the only resident that was down his hall because E6 and E10 (CNA's) had moved residents from their room to the day room. E19's statement indicates that E11 (LPN) was working on R1.</p> <p>1. The facility fire drill report dated 1/1/17 for actual fire indicates that the fire department received that signal at 9:00 am. On 1/25/17 at</p>	S9999		

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S9999	<p>Continued From page 19</p> <p>12:00pm E13 Maintenance Director stated that he does not know the exact time that the alarm signal was received at the fire department. E13 stated that the alarm sounded in the 9:00 am hour. The city fire department incident report dated 1/1/17 indicates that the paramedics were dispatched at 9:57 am and arrived at the facility at 10:04 am. The city fire department report indicates: upon arrival R1 was found in the lobby; R1 was possibly smoking in his room with oxygen on and bed caught fire; R1 suffered burns to hair. The city fire department report also indicates that R1 was unresponsive, with no respirations and no carotid pulse. The report indicates that R1 was pronounced dead on arrival at 10:30 am in the field.</p> <p>On 1/19/17 at 12:15 pm, the question was asked, "What do you do if an actual fire is observed?" E11 LPN replied call a code red, run to get the extinguisher, check rooms to make sure residents are safe. E11 stated that when a fire alarm sounds the staff get the fire extinguisher and walk around their assigned station to make sure residents are safe.</p> <p>On 1/19/17 at 12:20 pm, when asked what you do if an actual fire is observed, E14 CNA replied rescue the residents, inform the nurse, evacuate, get the fire extinguisher, and close the room doors. When asked if there is an actual fire what do you do for the other residents who in their rooms down the same hall as the fire, E14 replied close their room doors.</p> <p>On 1/19/17 at 12:25 pm, when asked what do you do if an actual fire is observed, E15 CNA replied pull alarm, alert staff, and check residents for safety. When asked what do you do for the residents that are in the hall where the fire is</p>	S9999		
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S9999	<p>Continued From page 20</p> <p>located, E15 replied that staff would close the room doors of residents in room to keep them safe.</p> <p>On 1/19/17 at 12:30 pm, when asked what do you do if an actual fire is observed, E10 CNA replied that you should try to extinguish the fire and rescue the resident.</p> <p>On 1/19/17 at 12:37 pm, when asked what staff should do if there is a fire, E13 Maintenance Director replied that staff should clear halls, close doors and listen for further instructions. E13 stated that residents who are in their rooms in the hall where the fire is located should be moved to a safe area behind the fire doors. E13 stated that the staff can try to extinguish the fire if they feel comfortable.</p> <p>The facility's course completion history for workplace emergencies and natural disasters: an overview does not include documentation to support that E6 completed the course in 2016. On 1/19/17 at 2:10 pm E2 Assistant Administrator stated that E6 has been employed at the facility for 2 years and 4 months. The facility's fire drill report dated 12/17/16 indicates that E6 participated in a false alarm drill.</p> <p>The facility's staff response to fire policy revised 3/14 indicates that the employee who first discovers the fire/smoke will perform task in this order:</p> <p>Rescue the individual(s) in immediate danger; shout code red to alert staff; activate the nearest alarm pull station; contain the fire by closing the door to the room; extinguish the fire with a fire extinguisher if the fire is small - no larger than a trash can. The policy indicates that staff will:</p>	S9999		
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S9999	<p>Continued From page 21</p> <p>Evacuate the immediate area, continuing to evacuate all occupants out of the smoke compartment to a safe area beyond the smoke compartment doors and behind a second set of doors if possible; keep the fire contained by closing the door, assist in moving residents to a safe area.</p> <p style="text-align: center;">(A)</p>	S9999		