| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| BRIAN CTR HEALTH & REHAB/HENDERSONVILLE | 1870 PISGAH DRIVE HENDERSONVILLE, NC 28791 |

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| F 000 | INITIAL COMMENTS<br><br>1. 483.25 (F323) at J<br>Immediate Jeopardy began on 12/06/16 when Resident #2 went outside with his oxygen tank running, the nasal cannula in his nares, and lit a cigarette which resulted in him catching himself on fire resulting in second degree facial and hand burns and staff did not effectively attempt to extinguish the fire and left the resident unattended. Immediate jeopardy was removed on 12/21/16 at 3:26 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to supervision to prevent accidents.<br><br>2. 483.75 (F490) at J<br>Immediate jeopardy began on 12/06/16 when Resident #2 went outside with his oxygen tank running, the nasal cannula in his nares, away from the designated smoking area and lit a cigarette which resulted in him catching himself on fire resulting in second degree facial and hand burns. Nurse Aide #1 who was in a nearby area at the time of the incident, failed to effectively intervene when she saw Resident #2 on fire. She left the resident on fire outside blocking the facility door as she ran around the building to the front door while calling 911 in order to obtain additional staff assistance. Immediate jeopardy was removed on 12/21/16 at 3:26 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out | F 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 01/20/2017

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| F 000 | Continued From page 1 | F 000 | | |

of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to supervision, oxygen storage and use, smoking material storage and staff preparedness to extinguish a resident who is on fire.

3. 483.75 (518) at J
Immediate Jeopardy began on 12/06/16 when Resident #2 went outside with his oxygen tank running, the nasal cannula in his nares, away from the designated smoking area and lit a cigarette which resulted in him catching himself on fire resulting in second degree facial and hand burns. Nurse Aide #1 who was in a nearby area at the time of the incident, failed to attempt to put out the flames via the use a fire extinguisher or fire blanket which were nearby. She left the resident on fire outside blocking the facility door as she attempted to obtain assistance by entering another facility door. Immediate jeopardy was removed on 12/21/16 at 3:26 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to staff being prepared to extinguish a resident who is on fire.

An amended Statement of Deficiencies was provided to the facility on 01/24/17 to correct typographical errors that were in the original CMS 2567 report. Event ID# HH2B11.

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| F 323 SS=J | 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>(d) Accidents.<br>The facility must ensure that -<br><br>(1) The resident environment remains as free from accident hazards as is possible; and<br><br>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.<br><br>(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, staff interviews, and resident interviews, the facility failed to keep 2 of 2 sampled residents who smoked and utilized oxygen therapy from smoking with their oxygen tanks connected to the back of their wheelchairs (Residents #2 and #4). Resident #2 sustained 2nd degree burns to his face and hand when his oxygen tubing ignited as he was smoking with his oxygen cannula in place and oxygen running. The facility failed to | F 323 | F323<br>1. On 12/6/16 Resident #2 was immediately assessed by the Charge Nurse and the EMS Responder then transferred to the Emergency Room for further evaluation and admission. He returned to the facility on 12/7/16 and has declined to smoke since his hospitalization.<br>Resident #4 discharged from the facility | 1/20/17 |

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immediately implement an effective intervention to extinguish the fire and left the resident unattended. Resident #4 was observed smoking under staff supervision with her oxygen tank on the back of her wheelchair but turned to the off position.

Immediate Jeopardy began on 12/06/16 when Resident #2 went outside with his oxygen tank running, the nasal cannula in his nares, and lit a cigarette which resulted in him catching himself on fire resulting in second degree facial and hand burns and staff did not effectively attempt to extinguish the fire and left the resident unattended. Immediate jeopardy was removed on 12/21/16 at 3:26 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to supervision to prevent accidents.

The findings included:

The facility's Safe Smoking / Tobacco Use Policy, revised November 2016, included:
*"Warning: Smoking is NOT permitted while oxygen is in use." and
*staff members maintain all smoking materials as appropriate and distribute smoking materials to residents at smoking times.

The facility's Oxygen Storage and Assembly policy revised June 2007 included "Do not smoke or allow others to smoke within 10 feet while oxygen is in use."

on 1/7/17.
Summary of event:
On 12/6/16 at approximately 8:30pm Resident # 2 was observed sitting outside the 400 Hall Door near the Resident and Staff smoking area by CNA #1 who was exiting the facility, she did not notice if Resident #2 was smoking. CNA# 1 walked past Resident # 2 to the staff smoking area less than 10 feet away, as she turned to sit down at the picnic table she noticed flames at Resident #2□s face and hands. CNA#1 immediately noticed that Resident # 2 had an oxygen tank on his wheelchair and a cannula in his nares, she attempted to turn off the Oxygen at the regulator but Resident #2 was flailing his arms and had positioned himself with the back of the wheelchair against the door and she was unable to reach the regulator. She was also unable to re-enter the facility for help because the wheelchair was blocking the door. CNA#1 was reluctant to cover the resident with the Fire Blanket for fear of trapping more oxygen and worsening the flames. CNA#1 then ran around the left corner of the facility and called 911 on her cellphone as she was running to the front door of the facility for help. As she entered the facility she notified the Charge Nurse #1 and the Supervisor #1. Charge Nurse# 1 immediately ran to the 400 Hall Door and Resident #2 was no longer located there, he had extinguished the flames and returned to his Resident Room # 207. As the Charge Nurse #1 entered the Resident Room #207 she noticed Resident #2 had applied his nebulizer

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1. Resident #2 was admitted to the facility on 06/03/16. His diagnoses included acute respiratory failure, chronic obstructive pulmonary disease (COPD), and being oxygen dependent.

Review of physician orders since 06/03/16 revealed oxygen was to be administered continuously at 3 liters per minute.

A Safe Smoking Evaluation dated 10/05/16 and completed by Minimum Data Set (MDS) Nurse #1 assessed Resident #2 as able to communicate that smoking materials were for personal use only, that smoking materials were for use only in the designated smoking area, and that the resident was able to physically hold the smoking device while smoking. Upon observations it was noted that he could light and smoke a cigarette while demonstrating safe technique for putting out the matches, lights and disposing of ash and that he remained alert during the course of smoking. The evaluation determined Resident #2 was a safe smoker and no supervision was required while smoking. Under the notes section was "instructed not to use O2 (oxygen) when out smoking and voiced understanding."

During an interview with the Minimum Data Set (MDS) Nurse #1 conducted on 12/20/16 at 9:35 AM revealed that she watched Resident #2 smoke during his smoking assessment in October 2016. She stated she assessed him while smoking in his wheelchair with the oxygen tank located on the back of his wheelchair. She further stated that she made sure the oxygen tank was turned off but could not recall if he turned it off or if she just made sure it was turned off. MDS Nurse #2, present at this interview, and

mask and started a nebulizer treatment, he stated I am fine, just need to finish my breathing treatment. Charge Nurse # 1 and Supervisor # 1 immediately removed the mask and began to assess Resident #2 for injuries. Observations included black soot to the lower half of his face and singed hair on the left side of his head and surrounding his face. The Fire Department and the Emergency Medical Services arrived and immediately transported Resident #2 to the Emergency Room, where he was admitted in stable condition to the ICU for observation of burns to the nasal area and respiratory monitoring. On 12/6/16 Supervisor # 1 notified Resident #2□s daughter, the On Call Physician, the Facility Medical Director, the Facility Administrator and the Facility Director of Nursing. Facility Administration including the Administrator and Director of Nursing developed an immediate and interim plan to ensure safe smoking that included assigning an attendant to the Resident Smoking Area to ensure all Residents attempting to smoke were provided supervision, 12 residents were identified as current smokers and were re-assessed to determine status for oxygen use and to designate supervised or unsupervised smoking status. A meeting was conducted on 12/7/16 at 1pm with the Administrator and Director of Nursing and the District Support team to complete a full investigation into the events occurring on 12/6/16 involving Resident #2 and a Root Cause Analysis and further development of a permanent plan to

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| F 323 | Continued From page 5<br>MDS Nurse #1 both stated they had observed Resident #2 smoking in the designated smoking area while in his wheelchair with the oxygen tank located on the back of the wheelchair. Both MDS Nurse #1 and MDS Nurse #2 stated they did not question the safety of smoking with an oxygen tank in the same area as this practice was normal for the facility.<br><br>Resident #2's quarterly MDS dated 11/30/16 coded him with intact cognition, having no mood issues or behavior issues, and required supervision with bed mobility, transfers, walking, locomotion, dressing, eating and hygiene. He was coded as having impaired vision, unable to read newspaper/book print, and having no functional limitations to his upper and lower extremities. He was coded as receiving oxygen therapy.<br><br>Review of the Situation, Background, Assessment, Recommendation (SBAR) report dated 12/06/16 revealed Resident #2 was outside smoking and his oxygen tubing caught fire. His hair was singed and his nose had black singed areas. This report also indicated he stated he thought his oxygen was off. The Incident/Accident Investigation Follow-up dated 12/06/16 revealed Resident #2 was out smoking with his oxygen on and set fire to his hair and face. Resident #2 was sent to the emergency room. The new intervention listed to prevent reoccurrence was for supervised smoking.<br><br>Review of the hospital history and physical dated 12/06/16 revealed Resident #2 was assessed with 10 to 19% burn (any degree) of his body surface. He was noted to have second degree burns to his bilateral nares and left hand. | F 323 | ensure safe resident smoking.<br>Resident #2 is alert and oriented with a BIMS score of 15 last assessed 9/2/16 with no recent changes in condition or mental status. His last Smoking assessment was completed on 10/5/16 at which time he was deemed safe smoker.<br>On 10/5/16 the nurse educated Resident #2 to remove his oxygen prior to smoking and he verbalized understanding.<br>Resident # 2 was care planned as a safe smoker and able to remove his own oxygen prior to smoking.<br>On 12/20/16 Resident #4, who uses oxygen on an as needed basis, was reviewed by the Director of Nursing. Resident #4□s assessment and care plan were validated as a supervised smoker, smoking was observed and oxygen tank removed from wheelchair prior to entering the designated smoking area.<br>On 12/20/16 CNA #1 received one on one education by the Director of Nursing to include the facility□s policy regarding Fire Management, Fire Extinguisher usage, the use of a Fire Blanket to extinguish a personal fire, turning off any Oxygen in use during a fire, and to supervise and attend to a resident during an emergency situation by not leaving the resident until further assistance has arrived.<br><br>2. Current Residents who smoke have the potential to be affected by this practice.<br>By 12/7/16 the Director of Nursing and Nurse Managers completed new Smoking Assessments for current residents who smoke to determine the need for | |

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| F 323 | Continued From page 6<br>Resident #2 was admitted to the intensive care unit for steroid intravenous therapy and close monitoring. The hospital discharge summary dated 12/08/16 included the discharge diagnoses as follows:<br>*principal problem was burn any degree involving 10-19% of body surface;<br>*active problems included partial thickness burn of face; 2nd degree burn of left hand; COPD exacerbation; chronic respiratory failure, chronic anemia, and tobacco abuse.<br><br>Resident #2 was readmitted to the facility 12/08/16 with physician orders for topically applied antibiotics to bilateral nares.<br><br>Observations on 12/19/16 at 10:01 AM the smoking area was observed and noted to have a fire extinguisher, fire blanket, and 3 bright signs stating smoking area no oxygen.<br><br>Nurse Aide (NA) #1 was interviewed on 12/19/16 at 12:22 PM. She stated she had seen Resident #2 smoke previous to the accident. She stated Resident #2 would turn his oxygen tank off before he went outside but generally smoked with the oxygen tank located on the back of his wheelchair. She stated she was never instructed that the oxygen tank should not be kept on the back of the wheelchair while he smoked. She stated she had concerns about the tank being present during smoking but no one told her otherwise. She stated she clocked out the night of 12/06/16 to go on break in the staff smoking area. She passed Resident #2 who was sitting in the alcove outside of the facility's exit leading to the smoking areas. She could not recall if he had oxygen in place or not. She proceeded to the staff smoking area and then heard a "popping | F 323 | supervised smoking and to evaluate the resident□s use of oxygen. Each Resident□s careplan was updated with individualized interventions based on the assessment to include:<br>A. The need for Supervision while smoking<br>B. The storage of smoking materials<br>C. The use of smoking aprons<br>D. The management of oxygen while smoking<br>By 12/8/16 the Administrator and Director of Nursing conducted 2 meetings with 12 current residents who smoke to review and discuss the following:<br>A. The Facility Policy for Resident□s Safe Smoking<br>B. The Difference between Supervised and Unsupervised Smokers<br>C. The storage of smoking materials<br>D. The schedule for supervised smoking and allowing resident input in scheduling<br>E. Designated smoking area and available safety equipment- fire blanket, fire extinguisher and acceptable ashtrays and receptacles. Family and visitors interested in assisting residents to smoke will see the Nurse for direction prior to smoking and will be allowed in designated smoking areas.<br>F. Smoking attendant and use of umbrellas during inclement weather to travel to the designated smoking area.<br>G. Use of smoking aprons<br>H. Oxygen is not allowed in the Designated Smoking Area<br>3. Measures put in place to ensure the alleged deficient practice does not recur include: | |

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and crackling sound". She turned around and saw he had flames in front of his face. She stated he was flailing his arms and she could not get close to turn off the oxygen. He was situated in front of the door and she could not get inside the building so she ran to the front entrance of the building while at the same time she called 911. She stated she thought about using the fire blanket but was afraid that when she placed the blanket over his head, the running oxygen would gather under the blanket and fuel the fire causing more damage and possibly causing the oxygen to explode. When she entered the facility and got help, she and Nurse #1 and Nurse #2, found him in his room with his breathing treatment in place.

Upon follow up interview via a phone call on 12/20/16 at 2:09 PM, NA #1 stated that she had been an emergency medical technician (EMT) 6 to 10 years ago. She stated that she was trained in the use of a fire blanket but knew it could either benefit someone or make it worse. She stated that she could not get close to him due to the flames and could not reach the oxygen tank to turn it off. She stated due to the fire, she felt the situation was unsafe for him and for her. She did not want to use the fire extinguisher because of his breathing problems and was afraid the fire blanket would create a pocket for the oxygen to build up and feed the fire. She left him in order to get help as he was blocking the door to reenter the facility and called 911 while going to get help. She stated she made the decisions she did based on her EMT training.

On 12/19/16 at 2:32 PM, Resident #2 was observed propelling himself down the hall in the wheelchair with oxygen running at 3 liters per minute. No signs were located on the back of his

On 12/8/16 a plan was developed to included educating Facility Staff, current Residents who smoke, and Residents Families on re-implementation of the Facility Policy for Safe Smoking, new requirements for storage of smoking materials, how Residents are assessed to determine needs for supervision during smoking, the facility schedule for supervised smoking, no Oxygen allowed in the designated smoking areas, no smoking allowed outside of the designated area.
As part of this plan a smoking attendant was assigned to monitor the designated smoking area and another attendant to monitor non-designated areas on 12/7/16. These smoking attendants will assist Residents to the designated smoking area and monitor for use of smoking aprons and no oxygen use. These attendants will also monitor non-designated areas to ensure there is no smoking in these areas. Any issues with compliance will be reported to the Administrator or Director of Nursing.

Education was completed as follows:

1. By 12/8/16 the Director of Nursing and Assistant Director of Nursing educated the Facility staff on regarding the Facility Policy for Safe Smoking to include the following:

A. Assessment and Care Planning of current resident who smoke on admission and quarterly and as needed with changes. Designating resident as Supervised and Unsupervised smokers.

B. Receiving and Storing resident s

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| F 323 | Continued From page 8<br>wheelchair to alert people that oxygen was located on the wheelchair. He agreed to be interviewed at this time and proceeded to leave his wheelchair and oxygen in the hall as he walked into his room. Resident #2 was observed with slight pinkness on his cheeks where oxygen tubing would rest, his nares were shiny with what he stated was antibiotic ointment and his left hand had a scab about quarter size between the base of his thumb and base of his forefinger, which he stated was from the fire. Resident #2 stated he had been watching television in the activity room when he decided to go outside to smoke. At that time he was permitted to keep his own lighter and cigarettes. He stated the wind was blowing so he stayed close to the door of the building, not in the designated smoking area of the gazebo area and lit his cigarette. He stated he had forgotten his oxygen tubing was on his face and the oxygen was running at this time. He stated when he went to take another puff on the cigarette and flames "flashed" up. Resident #2 stated he burned his cannula, eyebrows, nose and hand as he yanked the nasal cannula off his face. He then stated the fire just went out. He further stated a staff member was outside and she got scared and ran around the building to get help. Once the flames were out, he went back inside the building to his room and applied his nebulizer treatment. Resident #2 stated he didn't realize he was hurt until staff and the emergency medical services (EMS) arrived. Resident #2 stated that he had always gone outside with his oxygen on the back of his wheelchair. He stated he always remembered to remove the cannula and place it away from the flames/cigarette. Resident #2 stated the tank would still be running sometimes but the cannula would be away from the cigarette. Resident #2 stated he was never | F 323 | smoking materials<br>C. Location of Designated Smoking Areas for Residents and Staff. Directing visitors who want to assist a resident to smoke.<br>D. Smoking schedules and Supervision of smokers in designated smoking areas and the use of smoking aprons. Location and use of safety equipment in this area including the fire blanket, the fire extinguisher and ashtrays and receptacles.<br>E. There is no Oxygen allowed in the designated smoking are<br>Additional education was provided on 12/20/16 to all facility staff by the Administrator, Director of Nursing , Area Staff Development Director and Nurse Managers to include:<br>-the Facility policy for Fire Management<br>- Fire Extinguisher usage to include the Pull, Aim, Squeeze and Sweep method for effective fire extinguishing<br>-use of a Fire Blanket to cover and smother flames to manage a personal fire<br>-discontinuing any Oxygen in use and removing the tank as soon as possible during a fire<br>-Supervise and attend to a Resident during an emergency situation by not leaving the resident until further assistance has arrived<br>No staff shall work after 12/20/16 before receiving this education. This education has been added to the Facility Orientation program for all new hires and agency staff to be completed prior to beginning work in resident care areas after 12/20/16.<br>2. By 12/8/16 the Administrator and | |

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| F 323 | Continued From page 9<br>told that he could not have his tank with him when he went outside to smoke.<br><br>On 12/19/16 at 3:19 PM an interview with housekeeper #1 revealed she had seen Resident #2 smoke outside and he would have turned his oxygen tank off. She further stated he would keep the oxygen tank on the back of his wheelchair while he smoked after removing the nasal cannula and hanging it on the oxygen tank.<br><br>On 12/19/16 at 3:24 PM Resident #10, assessed on the MDS dated 11/16/16 as cognitively intact, stated that when he had been outside smoking, Resident #2 had come out smoking with his oxygen tank on the back of the wheelchair. He stated that most of the times, Resident #2 turned the tank off. At times, he and other residents expressed concern to Resident #2 about the dangers of smoking with oxygen. Staff would be in their smoking area, about 20 feet away and visible between the two areas. He never told anyone of his concerns.<br><br>The Nurse #1 stated on 12/19/16 at 4:21 PM that she had seen Resident #2 smoke but did not recall him smoking with oxygen in place. She stated she responded to NA #1 and another staff running in the building looking for Resident #2 saying he was on fire. Nurse #1 stated she located him in his room with soot on his face, near his eyebrows and had singed hair. NA #1 had already called 911.<br><br>Interview with the Director of Nursing (DON) on 12/19/16 at 5:50 PM revealed she had not observed the residents smoke since coming to this facility a few months ago. | F 323 | Director of Nursing conducted 2 meetings with 12 current residents who smoke and their families to review and discuss the following:<br>A. The Facility Policy for Resident□s Safe Smoking<br>B. The Difference between Supervised and Unsupervised Smokers<br>C. The storage of smoking materials<br>D. The schedule for supervised smoking and allowing resident input in scheduling<br>E. Designated smoking area and available safety equipment- fire blanket, fire extinguisher and acceptable ashtrays and receptacles. Family and visitors interested in assisting residents to smoke will see the Nurse for direction prior to smoking and will be allowed in designated smoking areas.<br>F. Smoking attendant and use of umbrellas during inclement weather to travel to the designated smoking area.<br>G. Use of smoking aprons<br>H. Oxygen is not allowed in the Designated Smoking Area<br>New Residents who smoke and are admitted after 12/8/16 will receive this education when the Smoking Assessment is completed and Care Plan developed. The Facility□s new Admission packet has been updated to include this information and education.<br>The Administrator, Director of Nursing or Nurse Manager are monitoring the resident smoking area daily on each shift for 30 days, 3 times per week on each shift for 8 weeks to validate residents are smoking in designated areas, safety equipment including the smoking aprons, | |

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| F 323 | Continued From page 10<br>Interview with the Staff Development Coordinator on 12/20/16 at 9:26 AM revealed that prior to Resident #2's smoking accident, she included training about the designated smoking area and the need to remove all oxygen prior to residents smoking in her orientation of new employees.<br><br>On 12/20/16 at 10:03 AM, the Administrator stated she was unaware that residents were smoking with their oxygen tanks in the smoking area until 12/06/16.<br><br>Resident #5, assessed per the MDS dated 09/20/16 as being cognitively intact, stated on 12/20/16 at 10:21 AM that she had seen Resident #2 smoking with the oxygen tank on the back of his wheelchair. She stated staff were aware of this behavior and explained she witnessed staff on occasion reminding Resident #2 to make sure his oxygen tank was turned off.<br><br>Interview with the Maintenance Supervisor on 12/20/16 at 3:30 PM revealed that he trained all new employees prior to Resident #2's accident on the location of fire alarms, fire extinguishers and fire blanket. He stated there had been 2 paper signs located in plastic sleeves at the gazebo area stating this was a smoking area and no oxygen was allowed. These paper signs had been replaced since the accident with larger, brighter, sturdier ones.<br><br>Nurse #2 was interviewed on 12/20/16 at 4:47 PM. Nurse #2 stated that per her own observations, Resident #2 smoked with the oxygen tank on the back of his wheelchair but had the tank turned off. Nurse #2 responded to NA #1 alerting staff she had seen him on fire. Nurse #2 stated she found him back in his room | F 323 | fire blanket, fire extinguisher, acceptable ashtrays and receptacles are available and in use as required. During this monitoring they are validating that Oxygen is removed prior to entering the designated smoking area. They are also validating that supervision is present for resident assessed as a supervised smoker. This monitoring will continue for 6 months and opportunities will be corrected immediately as they are identified.<br>4.<br>The Administrator and Director of Nursing will analyze the data obtained during this monitoring and report any patterns and/or trends to the QAPI Committee monthly for 12 months. The QAPI Committee will evaluate the effectiveness of the above plan and will add additional information based on the outcomes identified to ensure continued compliance<br>Date of Compliance 1/20/17 | |

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giving himself a breathing treatment she had left ready for him. She further stated that she had warned him about the tank being on the back of the wheelchair while he was smoking and he assured her staff the tank was turned off. She stated his upper lip and under his nose was blackened and the oxygen tubing had melted on his cheek. Nurse #2 stated she saw him smoke when she also smoked and he usually turned the oxygen tank off, wrapped up the nasal cannula and tubing and sat on it while he smoked.

2. Resident #4 was admitted to the facility on 08/29/16 with chronic obstructive pulmonary disease and dementia.

Resident #4's safe smoking assessment dated 10/04/16 stated she needed constant supervision with smoking.

Physician orders dated 11/29/16 included oxygen to be administered via nasal cannula at 2 liters per minute as needed to keep oxygen levels above 90%.

The most recent Minimum Data Set dated 11/29/16 coded Resident #4 with moderately impaired cognition, adequate vision, requiring supervision for most activities of daily living skills. She was coded as using oxygen.

Interview with the Director of Nursing (DON) on 12/19/16 at 5:50 PM revealed she had not observed the residents smoke since coming to this facility a few months ago.

Interview with the Staff Development Coordinator on 12/20/16 at 9:26 AM revealed that prior to 12/06/16 she included training about the

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designated smoking area and the need to remove all oxygen prior to residents smoking in her orientation of new employees.

Interview with the MDS Nurses #1 and #2 on 12/20/16 at 9:35 AM, revealed they assessed residents for smoking safety by watching them smoke outside in the designated area. Both stated that each had observed Resident #4 since the assessment in the smoking area with the oxygen tank on the back of her wheelchair, explaining again it was permitted.

On 12/20/16 at 10:03 AM, the Administrator stated she was unaware that residents were smoking with their oxygen tanks in the smoking area until 12/06/16.

On 12/20/16 at 10:19 AM, Resident #4 was observed in the smoking area, wearing an apron being directly supervised by agency staff #1. She was in her wheelchair but had no oxygen tank or tubing with her. During this observation, Resident #4 appeared confused when she asked staff what she was doing and the agency staff who was monitoring her explained she was outside smoking. Observations revealed bright colored 'smoking area no oxygen' signs in front of the gazebo and inside the gazebo.

Interview with NA #2 on 12/20/16 at 10:15 AM revealed NA #2 supervised Resident #4 when smoking. She stated that the oxygen tank was usually on the back of her wheelchair during smoking as she was never instructed to remove the tank prior to taking her to smoke. NA #2 made sure the oxygen tank was turned off prior to lighting her cigarette. She further stated Resident #4 always kept her cigarettes in her coat pocket

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but did not have a lighter. NA #2 stated that all cigarettes and lighters were now kept locked up and anyone assessed as an unsafe smoker does not have access to the smoking materials.

Interview with the Maintenance Supervisor on 12/20/16 at 3:30 PM revealed that prior to 12/06/16 he trained all new employees on the location of fire alarms, fire extinguishers and fire blanket. He stated there had been 2 paper signs located in plastic sleeves at the gazebo area stating this was a smoking area and no oxygen was allowed. These paper signs had been replaced since 12/06/16 with larger, brighter, sturdier ones.

The Administrator and DON were informed of Immediate Jeopardy on 12/20/16 at 1:43 PM.

On 12/21/16 at 12:58 PM, the facility provided the following Credible Allegation of Compliance:

1. On 12/6/16 at approximately 8:30pm Resident #2 was observed sitting outside the 400 Hall Door near the Resident and Staff smoking area by NA #1 who was exiting the facility, she did not notice if Resident #2 was smoking. NA #1 walked past Resident #2 to the staff smoking area less than 10 feet away, as she turned to sit down at the picnic table she noticed flames at Resident #2's face and hands. NA#1 immediately noticed that Resident #2 had an oxygen tank on his wheelchair and a cannula in his nares, she attempted to turn off the oxygen at the regulator but Resident #2 was flailing his arms and had positioned himself with the back of the wheelchair against the door and she was unable to reach the regulator. She was also unable to re-enter the facility for help because the wheelchair was

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blocking the door. NA #1 was reluctant to cover the resident with the Fire Blanket for fear of trapping more oxygen and worsening the flames. NA #1 then ran around the left corner of the facility and called 911 on her cell phone as she was running to the front door of the facility for help. As she entered the facility she notified the Charge Nurse #1 and the Supervisor #1. Charge Nurse #1 immediately ran to the 400 Hall Door and Resident #2 was no longer located there, he had extinguished the flames and returned to his Resident Room # 207. As the Charge Nurse #1 entered the Resident Room #207 she noticed Resident #2 had applied his nebulizer mask and started a nebulizer treatment, he stated "I am fine, just need to finish my breathing treatment." Charge Nurse #1 and Supervisor #1 immediately removed the mask and began to assess Resident #2 for injuries. Observations included black soot to the lower half of his face and singed hair on the left side of his head and surrounding his face. The Fire Department and the Emergency Medical Services arrived and immediately transported Resident #2 to the Emergency Room, where he was admitted in stable condition to the ICU for observation of burns to the nasal area and respiratory monitoring. On 12/6/16 Supervisor #1 notified Resident #2's responsible party, the On Call Physician, the Facility Medical Director, the Facility Administrator and the Facility Director of Nursing. Facility Administration including the Administrator and Director of Nursing developed an immediate and interim plan to ensure safe smoking that included assigning an attendant to the Resident Smoking Area to ensure all Residents attempting to smoke were provided supervision, 12 residents were identified as current smokers and were re-assessed to determine status for oxygen use and to designate

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supervised or unsupervised smoking status. A meeting was conducted on 12/7/16 at 1pm with the Administrator and Director of Nursing and the District Support team to complete a full investigation into the events occurring on 12/6/16 involving Resident #2 and a Root Cause Analysis and further development of a permanent plan to ensure safe resident smoking.

Resident #2 is alert and oriented with a Brief Interview for Mental Status score of 15 last assessed 9/2/16 with no recent changes in condition or mental status. His last Smoking assessment was completed on 10/5/16 at which time he was deemed safe smoker. On 10/5/16 the nurse educated Resident #2 to remove his oxygen prior to smoking and he verbalized understanding. Resident #2 was care planned as a safe smoker and able to remove his own oxygen prior to smoking.

On 12/20/16 Resident #4, who uses oxygen on an as needed basis, was reviewed by the Director of Nursing. Resident #4's assessment and care plan were validated as a supervised smoker, smoking was observed and oxygen tank removed from wheelchair prior to entering the designated smoking area.

On 12/20/16 NA #1 received one on one education by the Director of Nursing to include the facility's policy regarding Fire Management, Fire Extinguisher usage, the use of a Fire Blanket to extinguish a personal fire, turning off any Oxygen in use during a fire, and to supervise and attend to a resident during an emergency situation by not leaving the resident until further assistance has arrived.

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| F 323 | Continued From page 16<br>2. Current Residents who smoke have the potential to be affected by this practice.<br><br>By 12/7/16 the Director of Nursing and Nurse Managers completed new Smoking Assessments for current residents who smoke to determine the need for supervised smoking and to evaluate the resident's use of Oxygen. Each Resident's care plan was updated with individualized interventions based on the assessment to include:<br><br>A. The need for Supervision while smoking<br>B. The storage of smoking materials<br>C. The use of smoking aprons<br>D. The management of oxygen while smoking<br><br>By 12/8/16 the Administrator and Director of Nursing conducted 2 meetings with 12 current residents who smoke to review and discuss the following:<br><br>A. The Facility Policy for Resident's Safe Smoking<br>B. The Difference between Supervised and Unsupervised Smokers<br>C. The storage of smoking materials<br>D. The schedule for supervised smoking and allowing resident input in scheduling<br>E. Designated smoking area and available safety equipment- fire blanket, fire extinguisher and acceptable ashtrays and receptacles. Family and visitors interested in assisting residents to smoke will see the Nurse for direction prior to smoking and will be allowed in designated smoking areas.<br>F. Smoking attendant and use of umbrellas during inclement weather to travel to the designated smoking area.<br>G. Use of smoking aprons<br>H. Oxygen is not allowed in the Designated | F 323 | | |

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| F 323 | Continued From page 17<br>Smoking Area<br><br>3. Measures put in place to ensure the alleged deficient practice does not recur include:<br>On 12/8/16 a plan was developed to included educating Facility Staff, current Residents who smoke, and Residents' Families on re-implementation of the Facility Policy for Safe Smoking, new requirements for storage of smoking materials, how Residents are assessed to determine needs for supervision during smoking, the facility schedule for supervised smoking, no Oxygen allowed in the designated smoking areas, no smoking allowed outside of the designated area.<br><br>As part of this plan a smoking attendant was assigned to monitor the designated smoking area and another attendant to monitor non-designated areas on 12/7/16. These smoking attendants will assist Residents to the designated smoking area and monitor for use of smoking aprons and no oxygen use. These attendants will also monitor non-designated areas to ensure there is no smoking in these areas. Any issues with compliance will be reported to the Administrator or Director of Nursing.<br><br>Education was completed as follows:<br><br>1. By 12/8/16 the Director of Nursing and Assistant Director of Nursing educated the Facility staff on regarding the Facility Policy for Safe Smoking to include the following:<br><br>A. Assessment and Care Planning of current resident who smoke on admission and quarterly and as needed with changes. Designating resident as Supervised and Unsupervised | F 323 | | |

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| F 323 | Continued From page 18<br>smokers.<br>B. Receiving and Storing resident's smoking materials.<br>C. Location of Designated Smoking Areas for Residents and Staff. Directing visitors who want to assist a resident to smoke.<br>D. Smoking schedules and Supervision of smokers in designated smoking areas and the use of smoking aprons. Location and use of safety equipment in this area including the fire blanket, the fire extinguisher and ashtrays and receptacles.<br>E. There is no Oxygen allowed in the designated smoking area.<br><br>Additional education was provided on 12/20/16 to all facility staff by the Administrator, Director of Nursing, Area Staff Development Director and Nurse Managers to include:<br><br>-the Facility policy for Fire Management<br>- Fire Extinguisher usage to include the Pull, Aim, Squeeze and Sweep method for effective fire extinguishing<br>-use of a Fire Blanket to cover and smother flames to manage a personal fire<br>-discontinuing any Oxygen in use and removing the tank as soon as possible during a fire<br>-Supervise and attend to a Resident during an emergency situation by not leaving the resident until further assistance has arrived<br><br>No staff shall work after 12/20/16 before receiving this education. This education has been added to the Facility Orientation program for all new hires and agency staff to be completed prior to beginning work in resident care areas after 12/20/16. | F 323 | | |

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2. By 12/8/16 the Administrator and Director of Nursing conducted 2 meetings with 12 current residents who smoke and their families to review and discuss the following:

A. The Facility Policy for Resident's Safe Smoking
B. The Difference between Supervised and Unsupervised Smokers
C. The storage of smoking materials
D. The schedule for supervised smoking and allowing resident input in scheduling
E. Designated smoking area and available safety equipment- fire blanket, fire extinguisher and acceptable ashtrays and receptacles. Family and visitors interested in assisting residents to smoke will see the Nurse for direction prior to smoking and will be allowed in designated smoking areas.
F. Smoking attendant and use of umbrellas during inclement weather to travel to the designated smoking area.
G. Use of smoking aprons
H. Oxygen is not allowed in the Designated Smoking Area

New Residents who smoke and are admitted after 12/8/16 will receive this education when the Smoking Assessment is completed and Care Plan developed.

The Facility's new Admission packet has been updated to include this information and education.

Immediate jeopardy was removed on 12/21/16 at 3:26 PM when interviews with residents, nursing staff, administrative staff and non-nursing staff confirmed they had receiving in-service training on the facility's policy to remove all oxygen tanks

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| F 323 | Continued From page 20<br>and tubing prior to going into the designated smoking area, the new storage system for smoking materials, the available smoking equipment including smoking aprons, ashtrays, fire extinguisher and fire blankets, the returned demonstration of how to use a smoking blanket and what actions to take when a resident was found on fire. | F 323 | | |
| F 490 SS=J | 483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING<br><br>483.70 Administration.<br>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review, resident interviews, and staff interviews, the administration failed to oversee and enforce the facility's smoking policy and procedures to ensure 2 of 2 sampled residents (Residents #2 and #4) who smoked and utilized oxygen did not smoke with oxygen tanks on their wheelchairs and that staff were educated and followed the smoking policy. In addition, the administration failed to provide leadership in ensuring staff was adequately prepared to react in an emergency situation when one resident (Resident #2) caught fire while smoking with oxygen running resulting in 2nd degree burns on his face and hand.<br><br>Immediate jeopardy began on 12/06/16 when Resident #2 went outside with his oxygen tank running, the nasal cannula in his nares, away from the designated smoking area and lit a | F 490 | F490<br>1. On 12/6/16 Resident #2 was immediately assessed by the Charge Nurse and the EMS Responder then transferred to the Emergency Room for further evaluation and admission. He returned to the facility on 12/7/16 and has declined to smoke since his hospitalization.<br>Resident #4 discharged from the facility on 1/7/17.<br>Summary of event:<br>On 12/6/16 at approximately 8:30pm Resident # 2 was observed sitting outside the 400 Hall Door near the Resident and Staff smoking area by CNA #1 who was exiting the facility, she did not notice if Resident #2 was smoking. CNA# 1 walked past Resident # 2 to the staff | 1/20/17 |

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| F 490 | Continued From page 21<br>cigarette which resulted in him catching himself on fire resulting in second degree facial and hand burns. Nurse Aide #1 who was in a nearby area at the time of the incident, failed to effectively intervene when she saw Resident #2 on fire. She left the resident on fire outside blocking the facility door as she ran around the building to the front door while calling 911 in order to obtain additional staff assistance. Immediate jeopardy was removed on 12/21/16 at 3:26 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to supervision, oxygen storage and use, smoking material storage and staff preparedness to extinguish a resident who is on fire.<br><br>The findings included:<br><br>1. Cross Refer to F323:<br>Based on observations, record review, staff interviews, and resident interviews, the facility failed to keep 2 of 2 sampled residents who smoked and utilized oxygen therapy from smoking with their oxygen tanks connected to the back of their wheelchairs (Residents #2 and #4). Resident #2 sustained 2nd degree burns to his face and hand when his oxygen tubing ignited as he was smoking with his oxygen cannula in place and oxygen running. The facility failed to immediately implement an effective intervention to extinguish the fire and left the resident unattended. Resident #4 was observed smoking under staff supervision with her oxygen tank on the back of her wheelchair but turned to the off | F 490 | smoking area less than 10 feet away, as she turned to sit down at the picnic table she noticed flames at Resident #2□s face and hands. CNA#1 immediately noticed that Resident # 2 had an oxygen tank on his wheelchair and a cannula in his nares, she attempted to turn off the Oxygen at the regulator but Resident #2 was flailing his arms and had positioned himself with the back of the wheelchair against the door and she was unable to reach the regulator. She was also unable to re-enter the facility for help because the wheelchair was blocking the door. CNA#1 was reluctant to cover the resident with the Fire Blanket for fear of trapping more oxygen and worsening the flames. CNA#1 then ran around the left corner of the facility and called 911 on her cellphone as she was running to the front door of the facility for help. As she entered the facility she notified the Charge Nurse #1 and the Supervisor #1. Charge Nurse# 1 immediately ran to the 400 Hall Door and Resident #2 was no longer located there, he had extinguished the flames and returned to his Resident Room # 207. As the Charge Nurse #1 entered the Resident Room #207 she noticed Resident #2 had applied his nebulizer mask and started a nebulizer treatment, he stated I am fine, just need to finish my breathing treatment. Charge Nurse # 1 and Supervisor # 1 immediately removed the mask and began to assess Resident #2 for injuries. Observations included black soot to the lower half of his face and singed hair on the left side of his head and surrounding his face. The Fire | |

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| F 490 | Continued From page 22<br>position.<br><br>2. Cross Refer to F518:<br>Based on record reviews, policy review, staff interviews and resident interviews, the facility failed to provide effective staff training on fire prevention and fire emergency measures which resulted in second degree burns for 1 of 2 oxygen dependent residents who smoked, Resident #2, who was found on fire while smoking with his oxygen flowing.<br><br>The facility Administrator and Director of Nursing were informed of Immediate Jeopardy on 12/20/16 at 1:43 PM.<br><br>The facility provided a credible allegation of compliance on 12/21/16 at 1:51 PM as follows:<br><br>1. On 12/6/16 at approximately 8:30pm Resident #2 was observed sitting outside the 400 Hall Door near the Resident and Staff smoking area by NA #1 who was exiting the facility, she did not notice if Resident #2 was smoking. NA #1 walked past Resident #2 to the staff smoking area less than 10 feet away, as she turned to sit down at the picnic table she noticed flames at Resident #2's face and hands. NA #1 immediately noticed that Resident #1 had an oxygen tank on his wheelchair and a cannula in his nares, she attempted to turn off the Oxygen at the regulator but Resident #2 was flailing his arms and had positioned himself with the back of the wheelchair against the door and she was unable to reach the regulator. She was also unable to re-enter the facility for help because the wheelchair was blocking the door. NA#1 was reluctant to cover the resident with the Fire Blanket for fear of trapping more oxygen and worsening the flames. | F 490 | Department and the Emergency Medical Services arrived and immediately transported Resident #2 to the Emergency Room, where he was admitted in stable condition to the ICU for observation of burns to the nasal area and respiratory monitoring. On 12/6/16 Supervisor # 1 notified Resident #2□s daughter, the On Call Physician, the Facility Medical Director, the Facility Administrator and the Facility Director of Nursing. Facility Administration including the Administrator and Director of Nursing developed an immediate and interim plan to ensure safe smoking that included assigning an attendant to the Resident Smoking Area to ensure all Residents attempting to smoke were provided supervision, 12 residents were identified as current smokers and were re-assessed to determine status for oxygen use and to designate supervised or unsupervised smoking status. A meeting was conducted on 12/7/16 at 1pm with the Administrator and Director of Nursing and the District Support team to complete a full investigation into the events occurring on 12/6/16 involving Resident #2 and a Root Cause Analysis and further development of a permanent plan to ensure safe resident smoking.<br>Resident #2 is alert and oriented with a BIMS score of 15 last assessed 9/2/16 with no recent changes in condition or mental status. His last Smoking assessment was completed on 10/5/16 at which time he was deemed safe smoker. On 10/5/16 the nurse educated Resident #2 to remove his oxygen prior to smoking | |

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| F 490 | Continued From page 23<br>NA#1 then ran around the left corner of the facility and called 911 on her cell phone as she was running to the front door of the facility for help. As she entered the facility she notified the Charge Nurse #1 and the Supervisor #1. Charge Nurse# 1 immediately ran to the 400 Hall Door and Resident #2 was no longer located there, he had extinguished the flames and returned to his Resident Room #207. As the Charge Nurse #1 entered the Resident Room #207 she noticed Resident #2 had applied his nebulizer mask and started a nebulizer treatment, he stated "I am fine, just need to finish my breathing treatment." Charge Nurse #1 and Supervisor #1 immediately removed the mask and began to assess Resident #2 for injuries. Observations included black soot to the lower half of his face and singed hair on the left side of his head and surrounding his face. The Fire Department and the Emergency Medical Services arrived and immediately transported Resident #2 to the Emergency Room, where he was admitted in stable condition to the ICU for observation of burns to the nasal area and respiratory monitoring. On 12/6/16 Supervisor #1 notified Resident #2's responsible party, the On Call Physician, the Facility Medical Director, the Facility Administrator and the Facility Director of Nursing. Facility Administration including the Administrator and Director of Nursing developed an immediate and interim plan to ensure safe smoking that included assigning an attendant to the Resident Smoking Area to ensure all Residents attempting to smoke were provided supervision, 12 residents were identified as current smokers and were re-assessed to determine status for oxygen use and to designate supervised or unsupervised smoking status. A meeting was conducted on 12/7/16 at 1pm with the Administrator and Director of Nursing and the | F 490 | and he verbalized understanding. Resident # 2 was care planned as a safe smoker and able to remove his own oxygen prior to smoking. On 12/20/16 Resident #4, who uses oxygen on an as needed basis, was reviewed by the Director of Nursing. Resident #4□s assessment and care plan were validated as a supervised smoker, smoking was observed and oxygen tank removed from wheelchair prior to entering the designated smoking area. On 12/20/16 CNA #1 received one on one education by the Director of Nursing to include the facility□s policy regarding Fire Management, Fire Extinguisher usage, the use of a Fire Blanket to extinguish a personal fire, turning off any Oxygen in use during a fire, and to supervise and attend to a resident during an emergency situation by not leaving the resident until further assistance has arrived.<br>2. Current Residents who smoke have the potential to be affected by this practice.<br>By 12/7/16 the Director of Nursing and Nurse Managers completed new Smoking Assessments for current residents who smoke to determine the need for supervised smoking and to evaluate the resident□s use of oxygen. Each Resident□s careplan was updated with individualized interventions based on the assessment to include:<br>A. The need for Supervision while smoking<br>B. The storage of smoking materials<br>C. The use of smoking aprons<br>D. The management of oxygen while | |

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| F 490 | Continued From page 24<br>District Support team to complete a full investigation into the events occurring on 12/6/16 involving Resident #2 and a Root Cause Analysis and further development of a permanent plan to ensure safe resident smoking.<br><br>Resident #2 is alert and oriented with a BIMS score of 15 last assessed 9/2/16 with no recent changes in condition or mental status. His last Smoking assessment was completed on 10/5/16 at which time he was deemed safe smoker. On 10/5/16 the nurse educated Resident #2 to remove his oxygen prior to smoking and he verbalized understanding. Resident #2 was care planned as a safe smoker and able to remove his own oxygen prior to smoking.<br><br>On 12/20/16 Resident #4, who uses oxygen on an as needed basis, was reviewed by the Director of Nursing. Resident #4 ' s assessment and care plan were validated as a supervised smoker, smoking was observed and oxygen tank removed from wheelchair prior to entering the designated smoking area.<br><br>On 12/20/16 NA #1 received one on one education by the Director of Nursing to include the facility ' s policy regarding Fire Management, Fire Extinguisher usage, the use of a Fire Blanket to extinguish a personal fire, turning off any Oxygen in use during a fire, and to supervise and attend to a resident during an emergency situation by not leaving the resident until further assistance has arrived.<br><br>2. Current Residents who smoke have the potential to be affected by this practice.<br><br>By 12/7/16 the Director of Nursing and Nurse | F 490 | smoking<br>By 12/8/16 the Administrator and Director of Nursing conducted 2 meetings with 12 current residents who smoke and their families to review and discuss the following:<br>A. The Facility Policy for Resident□s Safe Smoking<br>B. The Difference between Supervised and Unsupervised Smokers<br>C. The storage of smoking materials<br>D. The schedule for supervised smoking and allowing resident input in scheduling<br>E. Designated smoking area and available safety equipment- fire blanket, fire extinguisher and acceptable ashtrays and receptacles. Family and visitors interested in assisting residents to smoke will see the Nurse for direction prior to smoking and will be allowed in designated smoking areas.<br>F. Smoking attendant and use of umbrellas during inclement weather to travel to the designated smoking area.<br>G. Use of smoking aprons<br>H. Oxygen is not allowed in the Designated Smoking Area<br>New Residents who smoke and are admitted after 12/8/16 will receive this education when the Smoking Assessment is completed and Care Plan developed. The Facility□s new Admission packet has been updated to include this information and education.<br>3. Measures put in place to ensure the alleged deficient practice does not recur include:<br>On 12/7/16 the Administrator, Director of Nursing, District Director of Operation and | |

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| F 490 | Continued From page 25<br>Managers completed new Smoking Assessments for current residents who smoke to determine the need for supervised smoking and to evaluate the resident's use of oxygen. Each Resident's careplan was updated with individualized interventions based on the assessment to include:<br><br>A. The need for Supervision while smoking<br>B. The storage of smoking materials<br>C. The use of smoking aprons<br>D. The management of oxygen while smoking<br><br>By 12/8/16 the Administrator and Director of Nursing conducted 2 meetings with 12 current residents who smoke and their families to review and discuss the following:<br><br>A. The Facility Policy for Resident's Safe Smoking<br>B. The Difference between Supervised and Unsupervised Smokers<br>C. The storage of smoking materials<br>D. The schedule for supervised smoking and allowing resident input in scheduling<br>E. Designated smoking area and available safety equipment- fire blanket, fire extinguisher and acceptable ashtrays and receptacles. Family and visitors interested in assisting residents to smoke will see the Nurse for direction prior to smoking and will be allowed in designated smoking areas.<br>F. Smoking attendant and use of umbrellas during inclement weather to travel to the designated smoking area.<br>G. Use of smoking aprons<br>H. Oxygen is not allowed in the Designated Smoking Area | F 490 | District Director of Clinical Services held a meeting with the Interdisciplinary Team to conduct a Root Cause Analysis regarding Resident non-compliance with the Facility□s policy for Safe Smoking, safety for Residents who smoke and use Oxygen, and Residents identified smoking in areas not designated for smoking.<br>The Team reviewed the current policy, discussed the current method for assessing Residents, observed designated smoking area for environmental needs and improvements , addressed Oxygen storage prior to entering the designated smoking area, identified an opportunity with effective storage for resident□s smoking materials and recommended a need for monitoring both designated and non-designated areas to ensure compliance.<br>Based on the results of this Root Cause Analysis a plan was developed to included Facility specific policy and procedures to ensure safe smoking by Residents. A plan was developed by the Interdisciplinary team including the Administrator, Director of Nursing and Facility Department Heads to include Facility specific policy and procedures to ensure safe smoking by Residents.<br>These policies were implemented by educating current Facility Staff, current Residents who smoke, and Residents□ Families on the Facility Policy for Safe Smoking. New requirements for storage of smoking materials, how Residents are assessed to determine needs for supervision during smoking, the facility schedule for supervised smoking, no | |

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| F 490 | Continued From page 26<br>New Residents who smoke and are admitted after 12/8/16 will receive this education when the Smoking Assessment is completed and Care Plan developed. The Facility's new Admission packet has been updated to include this information and education.<br><br>3. Measures put in place to ensure the alleged deficient practice does not recur include:<br><br>On 12/7/16 the Administrator, Director of Nursing, District Director of Operation and District Director of Clinical Services held a meeting with the Interdisciplinary Team to conduct a Root Cause Analysis regarding Resident non-compliance with the Facility's policy for Safe Smoking, safety for Residents who smoke and use Oxygen, and Residents identified smoking in areas not designated for smoking.<br><br>The Team reviewed the current policy, discussed the current method for assessing Residents, observed designated smoking area for environmental needs and improvements, addressed Oxygen storage prior to entering the designated smoking area, identified an opportunity with effective storage for resident's smoking materials and recommended a need for monitoring both designated and non-designated areas to ensure compliance.<br><br>Based on the results of this Root Cause Analysis a plan was developed to included Facility specific policy and procedures to ensure safe smoking by Residents. A plan was developed by the Interdisciplinary team including the Administrator, Director of Nursing and Facility Department Heads to include Facility specific policy and procedures to ensure safe smoking by Residents. | F 490 | Oxygen allowed in the designated smoking areas, no smoking allowed outside of the designated area, and fire safety were included in this education. As part of this plan a smoking attendant was assigned to monitor the designated smoking area and another attendant to monitor non-designated areas on 12/7/16. These smoking attendants will assist Residents to the designated smoking area and monitor for use of smoking aprons and no oxygen use. These attendants will also monitor non-designated areas to ensure there is no smoking in these areas. Any issues with compliance will be reported to the Administrator or Director of Nursing.<br>Education was completed as follows:<br>1. By 12/8/16 the Director of Nursing and Assistant Director of Nursing educated the Facility staff including Administration, Nursing, Therapy, Housekeeping and Dietary regarding the Facility Policy for Safe Smoking to include the following:<br>A. Assessment and Care Planning of current resident who smoke on admission and quarterly and as needed with changes. Designating resident as Supervised and Unsupervised smokers.<br>B. Receiving and Storing resident□s smoking materials<br>C. Location of Designated Smoking Areas for Residents and Staff. Directing visitors who want to assist a resident to smoke.<br>D. Smoking schedules and Supervision of smokers in designated smoking areas and the use of smoking aprons. Location | |

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| F 490 | Continued From page 27<br>These policies were implemented by educating current Facility Staff, current Residents who smoke, and Residents' Families on the Facility Policy for Safe Smoking. New requirements for storage of smoking materials, how Residents are assessed to determine needs for supervision during smoking, the facility schedule for supervised smoking, no Oxygen allowed in the designated smoking areas, no smoking allowed outside of the designated area, and fire safety were included in this education.<br><br>As part of this plan a smoking attendant was assigned to monitor the designated smoking area and another attendant to monitor non-designated areas on 12/7/16. These smoking attendants will assist Residents to the designated smoking area and monitor for use of smoking aprons and no oxygen use. These attendants will also monitor non-designated areas to ensure there is no smoking in these areas. Any issues with compliance will be reported to the Administrator or Director of Nursing.<br><br>Education was completed as follows:<br><br>1. By 12/8/16 the Director of Nursing and Assistant Director of Nursing educated the Facility staff including Administration, Nursing, Therapy, Housekeeping and Dietary regarding the Facility Policy for Safe Smoking to include the following:<br><br>A. Assessment and Care Planning of current resident who smoke on admission and quarterly and as needed with changes. Designating resident as Supervised and Unsupervised smokers.<br>B. Receiving and Storing resident ' s smoking | F 490 | and use of safety equipment in this area including the fire blanket, the fire extinguisher and ashtrays and receptacles.<br>E. There is no Oxygen allowed in the designated smoking area<br>An educational plan was developed by the Interdisciplinary Team consisting of the Administrator, Director of Nursing, Social Services, Director of Rehab, Director of Housekeeping and Director of Dietary Services on 12/20/16 to include Facility specific policy and procedures for Fire Management and Smoking that address Oxygen is prohibited in designated smoking areas.<br>On 12/20/16 this Fire Safety educational plan was reviewed and further developed by the Administrator, Director of Nursing and the Area Staff Development Director with assistance from the District Field Support Team. This review included involvement with the local Fire Marshall who reviewed and accepted this plan.<br>Additional education was provided on 12/20/16 to all facility staff including Administration, Nursing, Therapy, Housekeeping and Dietary by the Administrator, Director of Nursing , Area Staff Development Director and Nurse Managers to include:<br>A. -The Facility policy and procedures for Fire Management, Smoking and that Oxygen is not prohibited in designated smoking areas.<br>B. -Fire Extinguisher usage to include the Pull, Aim, Squeeze and Sweep method for effective fire extinguishing as outlined in the facility policy for Fire | |

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| F 490 | Continued From page 28<br>materials<br>C. Location of Designated Smoking Areas for Residents and Staff. Directing visitors who want to assist a resident to smoke.<br>D. Smoking schedules and Supervision of smokers in designated smoking areas and the use of smoking aprons. Location and use of safety equipment in this area including the fire blanket, the fire extinguisher and ashtrays and receptacles.<br>E. There is no Oxygen allowed in the designated smoking area<br><br>An educational plan was developed by the Interdisciplinary Team consisting of the Administrator, Director of Nursing, Social Services, Director of Rehab, Director of Housekeeping and Director of Dietary Services on 12/20/16 to include Facility specific policy and procedures for Fire Management and Smoking that address Oxygen is prohibited in designated smoking areas.<br><br>On 12/20/16 this Fire Safety educational plan was reviewed and further developed by the Administrator, Director of Nursing and the Area Staff Development Director with assistance from the District Field Support Team. This review included involvement with the local Fire Marshall who reviewed and accepted this plan.<br><br>Additional education was provided on 12/20/16 to all facility staff including Administration, Nursing, Therapy, Housekeeping and Dietary by the Administrator, Director of Nursing, Area Staff Development Director and Nurse Managers to include:<br><br>A. -The Facility policy and procedures for Fire | F 490 | Management.<br>C. -Use of a Fire Blanket to cover and smother flames to manage a personal fire as outlined in the facility policy for Fire Management.<br>D. -Discontinuing any Oxygen in use and removing the tank as soon as possible during a fire as outlined by the facility policy for Fire Management.<br>E. -Supervise and attend to a Resident during an emergency situation by not leaving the resident until further assistance has arrived.<br>The Administrator and Director of Nursing will oversee this updated educational plan for completion and effectiveness during orientation and annual training based on observations and ongoing participation in training sessions. Monthly observation of education and return demonstration by staff during educational sessions will be observed and completed by the Administrator and Director of Nursing to validate the effectiveness of education for 6 months. Fire Drills will be conducted monthly by the Maintenance Director with oversight from the Administrator and Director of Nursing to further validate compliance.<br>Ongoing education will include additional Fire Safety training for current facility staff provided by the local Fire Marshall to be completed by January 15, 2017. This education will include:<br>-General Fire Safety with a video presentation<br>-When and How to correctly use a Fire Extinguisher<br>-When and How to correctly use a fire | |

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| F 490 | Continued From page 29<br>Management, Smoking and that Oxygen is not prohibited in designated smoking areas.<br>B. -Fire Extinguisher usage to include the Pull, Aim, Squeeze and Sweep method for effective fire extinguishing as outlined in the facility policy for Fire Management.<br>C. -Use of a Fire Blanket to cover and smother flames to manage a personal fire as outlined in the facility policy for Fire Management.<br>D. -Discontinuing any Oxygen in use and removing the tank as soon as possible during a fire as outlined by the facility policy for Fire Management.<br>E. -Supervise and attend to a Resident during an emergency situation by not leaving the resident until further assistance has arrived.<br><br>The Administrator and Director of Nursing will oversee this updated educational plan for completion and effectiveness during orientation and annual training based on observations and ongoing participation in training sessions. Monthly observation of education and return demonstration by staff during educational sessions will be observed and completed by the Administrator and Director of Nursing to validate the effectiveness of education for 6 months. Fire Drills will be conducted monthly by the Maintenance Director with oversight from the Administrator and Director of Nursing to further validate compliance.<br><br>Ongoing education will include additional Fire Safety training for current facility staff provided by the local Fire Marshall to be completed by January 15, 2017. This education will include:<br><br>-General Fire Safety with a video presentation<br>-When and How to correctly use a Fire | F 490 | Blanket<br>-Oxygen precautions with regards to Fire Safety<br>This training is scheduled on the following dates:<br>-January 4, 2017 at 7am<br>-January 5, 2017 at 2:30pm<br>-January 11, 2017 at 10am<br>-January 12, 2017 at 3:30pm<br>A Fire Safety Video has been provided by the local Fire Marshall for use with ongoing training.<br>The Administrator and Director of Nursing will have no tolerance for noncompliance with the Facility Safe Smoking policies and Fire Safety.<br>No staff shall work after 12/20/16 before receiving this education. This education has been added to the Facility Orientation program for all new hires and agency staff to be completed prior to beginning work in resident care areas after 12/20/16.<br>Ongoing Fire Safety training will be held annually for all facility staff and more frequently if an opportunity with compliance is identified.<br>The Administrator, Director of Nursing or Nurse Manager are monitoring the resident smoking area daily on each shift for 30 days, 3 times per week on each shift for 8 weeks, then weekly for 12 weeks to validate residents are smoking in designated areas, safety equipment including the smoking aprons, fire blanket, fire extinguisher, acceptable ashtrays and receptacles are available and in use as required. During this monitoring they are validating that Oxygen is removed prior to entering the designated smoking area. | |

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| F 490 | Continued From page 30<br>Extinguisher<br>-When and How to correctly use a fire Blanket<br>-Oxygen precautions with regards to Fire Safety<br><br>This training is scheduled on the following dates:<br><br>-January 4, 2017 at 7am<br>-January 5, 2017 at 2:30pm<br>-January 11, 2017 at 10am<br>-January 12, 2017 at 3:30pm<br><br>The Administrator and Director of Nursing will have no tolerance for noncompliance with the Facility Safe Smoking policies and Fire Safety.<br><br>No staff shall work after 12/20/16 before receiving this education. This education has been added to the Facility Orientation program for all new hires and agency staff to be completed prior to beginning work in resident care areas after 12/20/16. Ongoing Fire Safety training will be held annually for all facility staff and more frequently if an opportunity with compliance is identified.<br><br>Immediate jeopardy was removed on 12/21/16 at 3:26 PM when interviews with residents, nursing staff, administrative staff and non-nursing staff confirmed they had receiving in-service training on the facility's policy to remove all oxygen tanks and tubing prior to going into the designated smoking area, the new storage system for smoking materials, the available smoking equipment including smoking aprons, ashtrays, fire extinguisher and fire blankets, the returned demonstration of how to use a smoking blanket and what actions to take when a resident was found on fire. Interview with the 24/7 staff monitors and observations revealed all smoking | F 490 | They are also validating that supervision is present for resident assessed as a supervised smoker.<br>The Administrator or Director of Nursing will monitor observe orientation for new hires as it occurs and monthly fire drills for 6 months to validate Fire Safety Training is effective and completed as required.<br>This monitoring will continue for 6 months and opportunities will be corrected immediately as they are identified.<br>4.<br>The Administrator and Director of Nursing will analyze the data obtained during this monitoring and report any patterns and/or trends to the QAPI Committee monthly for 12 months. The QAPI Committee will evaluate the effectiveness of the above plan and will add additional information based on the outcomes identified to ensure continued compliance<br>Date of Compliance 1/20/17 | |

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| F 490 | Continued From page 31<br>materials were maintained in a secured location and verified by staff, all oxygen tanks were removed prior to going to the smoking area and supervision with necessary equipment was provided to all unsafe smokers. Interview with the administration revealed they observe the smoking area regularly to ensure that oxygen is maintained away from the smoking area in the designated area before residents enter the smoking area and oversee the education of staff related to emergency preparedness.<br>Administration put into place ongoing fire drill schedule and secured additional training from the local fire marshall. | F 490 | | |
| F 518 SS=J | 483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS<br><br>The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews, policy review, staff interviews and resident interviews, the facility failed to provide effective staff training on fire prevention and fire emergency measures which resulted in second degree burns for 1 of 2 oxygen dependent residents who smoked, Resident #2, who was found on fire while smoking with his oxygen flowing.<br><br>Immediate Jeopardy began on 12/06/16 when Resident #2 went outside with his oxygen tank running, the nasal cannula in his nares, away from the designated smoking area and lit a cigarette which resulted in him catching himself | F 518 | F518<br>1. On 12/6/16 Resident #2 was immediately assessed by the Charge Nurse and the EMS Responder then transferred to the Emergency Room for further evaluation and admission. He returned to the facility on 12/7/16 and has declined to smoke since his hospitalization.<br>Resident #4 discharged from the facility on 1/7/17.<br>Summary of event:<br>On 12/6/16 at approximately 8:30pm Resident # 2 was observed sitting outside | 1/20/17 |

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| F 518 | Continued From page 32<br>on fire resulting in second degree facial and hand burns. Nurse Aide #1 who was in a nearby area at the time of the incident, failed to attempt to put out the flames via the use a fire extinguisher or fire blanket which were nearby. She left the resident on fire outside blocking the facility door as she attempted to obtain assistance by entering another facility door. Immediate jeopardy was removed on 12/21/16 at 3:26 PM when the facility provided and implemented an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to staff being prepared to extinguish a resident who is on fire.<br><br>The findings included:<br><br>The facility's Fire policy for emergency preparedness revised June 2012 included the Emergency Directions under Fire Response-upon discovering fire or smoke:<br><br>1. Remove the residents from immediate danger.<br>2. Call aloud "Code Red" and the location of the fire.<br>3. Begin R.A.C.E. program = Rescue, Alarm, Confine and Extinguish/Evacuate.<br><br>The facility's Safe Smoking / Tobacco Use Policy, revised November 2016, included "Warning: Smoking is NOT permitted while oxygen is in use." Neither this policy nor the Fire policy revised June 2012 indicated the distance oxygen should be from any ignition source. | F 518 | the 400 Hall Door near the Resident and Staff smoking area by CNA #1 who was exiting the facility, she did not notice if Resident #2 was smoking. CNA# 1 walked past Resident # 2 to the staff smoking area less than 10 feet away, as she turned to sit down at the picnic table she noticed flames at Resident #2□s face and hands. CNA#1 immediately noticed that Resident # 2 had an oxygen tank on his wheelchair and a cannula in his nares, she attempted to turn off the Oxygen at the regulator but Resident #2 was flailing his arms and had positioned himself with the back of the wheelchair against the door and she was unable to reach the regulator. She was also unable to re-enter the facility for help because the wheelchair was blocking the door. CNA#1 was reluctant to cover the resident with the Fire Blanket for fear of trapping more oxygen and worsening the flames. CNA#1 then ran around the left corner of the facility and called 911 on her cellphone as she was running to the front door of the facility for help. As she entered the facility she notified the Charge Nurse #1 and the Supervisor #1. Charge Nurse# 1 immediately ran to the 400 Hall Door and Resident #2 was no longer located there, he had extinguished the flames and returned to his Resident Room # 207. As the Charge Nurse #1 entered the Resident Room #207 she noticed Resident #2 had applied his nebulizer mask and started a nebulizer treatment, he stated I am fine, just need to finish my breathing treatment. Charge Nurse # 1 and Supervisor # 1 immediately removed | |

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| F 518 | Continued From page 33<br>The facility's Oxygen Storage and Assembly policy revised June 2007 included "Do not smoke or allow others to smoke within 10 feet while oxygen is in use."<br><br>Resident #2 was admitted to the facility on 06/03/16. His diagnoses included acute respiratory failure, chronic obstructive pulmonary disease, and being oxygen dependent. Review of physician orders dated 06/03/16 included oxygen was to be administered continuously at 3 liters per minute.<br><br>A Safe Smoking Evaluation dated 10/05/16 and completed by Minimum Data Set (MDS) Nurse #1 assessed Resident #2 as a safe smoker and no supervision was required while smoking. Under the notes section was "instructed not to use O2 (oxygen) when out smoking and voiced understanding."<br><br>During an interview with the Minimum Data Set (MDS) Nurse #1 conducted on 12/20/16 at 9:35 AM revealed that she watched Resident #2 smoke during his smoking assessment in October 2016. She stated she assessed him in his wheelchair with the oxygen tank on the back of his wheelchair. She further stated that she made sure the oxygen tank was turned off but could not recall if he turned it off or if she just made sure it was turned off. MDS #1 stated that at the time of this assessment, oxygen was permitted to be with the resident in the smoking area as long as the tank was turned off. MDS Nurse #2, present at this interview, and MDS Nurse #1 both stated they had observed Resident #2 in the designated smoking area smoking with the oxygen tank on the back of his wheelchair and stated that prior to 12/06/16, they understood | F 518 | the mask and began to assess Resident #2 for injuries. Observations included black soot to the lower half of his face and singed hair on the left side of his head and surrounding his face. The Fire Department and the Emergency Medical Services arrived and immediately transported Resident #2 to the Emergency Room at, where he was admitted in stable condition to the ICU for observation of burns to the nasal area and respiratory monitoring. On 12/6/16 Supervisor # 1 notified Resident #2□s daughter, the On Call Physician, the Facility Medical Director, the Facility Administrator and the Facility Director of Nursing.<br>On 12/20/16 CNA #1 received one on one education by the Director of Nursing to include the facility□s policy regarding Fire Management, Fire Extinguisher usage, the use of a Fire Blanket to extinguish a personal fire, turning off any Oxygen in use during a fire, and to supervise and attend to a resident during an emergency situation by not leaving the resident until further assistance has arrived.<br><br>2. Current residents have the potential to be affected by this same alleged deficient practice.<br>By 12/8/16 the Director of Nursing and Assistant Director of Nursing educated all Facility staff including Administration, Nursing, Therapy, Housekeeping and Dietary regarding the Facility Policy for Safe Smoking to include the following:<br>- Location and use of safety equipment in this area including the fire blanket, the fire | |

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| F 518 | Continued From page 34<br>that oxygen was permitted in the smoking area as long as the oxygen tank was turned off.<br><br>Resident #2's quarterly MDS dated 11/30/16 coded him with intact cognition, having no mood issues or behavior issues, and required supervision with bed mobility, transfers, walking, locomotion, dressing, eating and hygiene. He had impaired vision, able to see large print not newspaper print and had no functional limitations of his upper and lower extremities. He was coded as receiving oxygen therapy.<br><br>Review of the Situation, Background, Assessment, Recommendation (SBAR) report dated 12/06/16 revealed Resident #2 was outside smoking and his oxygen tubing caught fire. His hair was singed and his nose had black singed areas. This report also indicated he stated he thought his oxygen was off. The Incident/Accident Investigation Follow-up dated 12/06/16 revealed Resident #2 was out smoking with his oxygen on and set fire to his hair and face. Resident was sent to the emergency room. The new intervention listed to prevent reoccurrence was for supervised smoking.<br><br>Review of the hospital history and physical dated 12/06/16 revealed Resident #2 was assessed with 10 to 19% burn (any degree) of his body surface. He was noted to have second degree burns to his bilateral nares and left hand. Resident #2 was admitted to the intensive care unit for intravenous steroids and close monitoring.<br><br>Resident #2 was readmitted to the facility 12/08/16 with physician orders for topically applied antibiotics to bilateral nares. | F 518 | extinguisher and ashtrays and receptacles.<br>On 12/20/16 an updated educational plan was developed by the Interdisciplinary Team consisting of the Administrator, Director of Nursing, Social Services, Director of Rehab, Director of Housekeeping and Director of Dietary Services on to include Facility specific policy and procedures for Fire Management and Smoking that address Oxygen is prohibited in designated smoking areas.<br>On 12/20/16 this Fire Safety educational plan was reviewed and further developed by the Administrator, Director of Nursing and the Area Staff Development Director with assistance from the District Field Support Team. This review included involvement with the local Fire Marshall who reviewed and accepted this plan.<br>On 12/20/16 all facility staff including Administration, Nursing, Therapy, Housekeeping and Dietary by the Administrator, Director of Nursing , Area Staff Development Director and Nurse Managers received this updated education to include:<br>-The Facility policy and procedures for Fire Management, Smoking and that Oxygen is not prohibited in designated smoking areas.<br>-Fire Extinguisher usage to include the Pull, Aim, Squeeze and Sweep method for effective fire extinguishing as outlined in the facility policy for Fire Management.<br>-Use of a Fire Blanket to cover and smother flames to manage a personal fire as outlined in the facility policy for Fire | |

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| F 518 | Continued From page 35<br>Nurse Aide (NA) #1 was interviewed on 12/19/16 at 12:22 PM. She stated she had seen Resident #2 smoke previous to the accident. She stated Resident #2 would turn his oxygen tank off before he went outside but generally smoked with the oxygen tank located on the back of his wheelchair. She stated she was never instructed that the oxygen tank should not be kept on the back of the wheelchair while he smoked. She stated she clocked out the night of 12/06/16 to go on break in the staff smoking area. She passed Resident #2 who was sitting in his wheelchair in the alcove just outside of the facility's exit leading to the smoking areas. She could not recall if he had oxygen in place or not. She proceeded to the staff smoking area and then heard a "popping and crackling sound." She turned around and saw he had flames in front of his face. She stated he was flailing his arms and she could not get close enough to turn off the oxygen tank. He was sitting backed up, blocking the door to the facility and she could not get inside the building. She stated she ran to the front entrance of the building to obtain help at the same time calling 911 on her cell phone. She stated she thought about using the fire blanket but was afraid that when she placed the blanket over Resident #2's head, the running oxygen would build up under the blanket and fuel the fire causing more damage and possibly causing the oxygen to explode.<br><br>Upon follow up interview via a phone call on 12/20/16 at 2:09 PM, NA #1 stated that she had been an emergency medical technician (EMT) 6 to 10 years ago. She stated that she was trained in the use of a fire blanket but knew it could either benefit someone or make it worse. She stated that she could not get close to him due to the | F 518 | Management.<br>-Discontinuing any Oxygen in use and removing the tank as soon as possible during a fire as outlined by the facility policy for Fire Management.<br>-Supervise and attend to a Resident during an emergency situation by not leaving the resident until further assistance has arrived.<br><br>The Administrator and Director of Nursing will oversee the ongoing implementation of this updated educational plan for completion and effectiveness during orientation and annual training based on observations and ongoing participation in training sessions. Monthly observation of education and return demonstration by staff during educational sessions will be observed and completed by the Administrator and Director of Nursing to validate the effectiveness of education for 6 months. Fire Drills will be conducted monthly by the Maintenance Director with oversight from the Administrator and Director of Nursing to further validate compliance.<br>Ongoing education will include additional Fire Safety training for current facility staff provided by the local Fire Marshall to be completed by January 15, 2017. This education will include:<br>-General Fire Safety with a video presentation<br>-When and How to correctly use a Fire Extinguisher<br>-When and How to correctly use a fire Blanket<br>-Oxygen precautions with regards to Fire | |

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| F 518 | Continued From page 36<br>flames and could not reach the oxygen tank to turn it off. She stated due to the fire, she felt the situation was unsafe for him and for her. She did not want to use the fire extinguisher because of his breathing problems and was afraid the fire blanket would create a pocket for the oxygen to build up and feed the fire. She left him in order to get help as he was blocking the door to reenter the facility and called 911 while going to get help. She stated she made the decisions she did based on her EMT training.<br><br>On 12/19/16 at 2:32 PM, Resident #2 was interviewed. Resident #2 was observed with slight pinkness on his cheeks where oxygen tubing would rest, his nares were shiny with what he stated was antibiotic ointment and his left hand had a scab about quarter size between the base of his thumb and base of his forefinger, which he stated was from the fire. Resident #2 stated he had been watching television in the activity room when he decided to go outside to smoke. At that time he was permitted to keep his own lighter and cigarettes. He stated the wind was blowing so he stayed close to the door of the building, not in the designated smoking area of the gazebo area and lit his cigarette. He stated he had forgotten his oxygen tubing was on his face and the oxygen was running at this time. He stated when he went to take another puff on the cigarette and flames "flashed" up. Resident #2 stated he burned his cannula, eyebrows, nose and hand as he yanked the nasal cannula off his face. He then stated the fire just went out. He further stated a staff member was outside and she got scared and ran around the building to get help. Once the flames were out, he went back inside the building to his room and applied his nebulizer treatment. Resident #2 stated he didn't | F 518 | Safety<br>This training is scheduled on the following dates:<br>-January 4, 2017 at 7am<br>-January 5, 2017 at 2:30pm<br>-January 11, 2017 at 10am<br>-January 12, 2017 at 3:30pm<br>A Fire Safety Video has been provided by the local Fire Marshall for use with ongoing training.<br>The Administrator and Director of Nursing will have no tolerance for noncompliance with the Facility Safe Smoking policies and Fire Safety.<br>No staff shall work after 12/20/16 before receiving this education. This education has been added to the Facility Orientation program for all new hires and agency staff to be completed prior to beginning work in resident care areas after 12/20/16. Ongoing Fire Safety training will be held annually for all facility staff and more frequently if an opportunity with compliance is identified<br>The Administrator, Director of Nursing or Nurse Manager are monitoring the resident smoking area daily on each shift for 30 days, 3 times per week on each shift for 8 weeks, then weekly for 12 weeks to validate residents are smoking in designated areas, safety equipment including the smoking aprons, fire blanket, fire extinguisher, acceptable ashtrays and receptacles are available and in use as required. During this monitoring they are validating that Oxygen is removed prior to entering the designated smoking area. They are also validating that supervision is present for resident assessed as a | |

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| F 518 | Continued From page 37<br>realize he was hurt until staff and the emergency medical services (EMS) arrived.<br><br>On 12/19/16 at 5:50 PM, the Director of Nursing (DON) stated that if a resident was on fire, she would expect staff to try to smother the fire with a fire blanket as long as there was no chance of blowing oneself up. She stated it depended on the location of the resident and where the fire was on the body. She stated each situation would be individualized and she would expect some form of rescue and or making the resident safe as possible. The DON further stated that when she listened to NA #1's explanation as to why she did not use the fire blanket and left Resident #2, it made logical sense to her and indicated NA #1 was thinking through the situation. She stated she supported the actions of NA #1 as the aide felt unsafe and wanted to get help immediately for Resident #2.<br><br>Interview with the Staff Development Coordinator (SDC) on 12/20/16 at 9:26 AM revealed that she trained all new employees about the designated smoking area and the need to remove all oxygen prior to residents smoking. She conducted fire training upon orientation which included a video staff watched. She stated that she reviewed how to use the fire extinguisher and talked about how there were no smoking products permitted in an unsecured location. She stated that smoking assessments were completed on admission, routinely and as needed for changes in condition. The SDC also stated that the Maintenance Supervisor also reviewed fire safety with employees.<br><br>Review of the 12 minute video included in orientation revealed staff were to know the | F 518 | supervised smoker.<br>The Administrator or Director of Nursing will monitor observe orientation for new hires as it occurs and monthly fire drills for 6 months to validate Fire Safety Training is effective and completed as required.<br>This monitoring will continue for 6 months and opportunities will be corrected immediately as they are identified.<br>4.<br>The Administrator and Director of Nursing will analyze the data obtained during this monitoring and report any patterns and/or trends to the QAPI Committee monthly for 12 months. The QAPI Committee will evaluate the effectiveness of the above plan and will add additional information based on the outcomes identified to ensure continued compliance<br>Date of Compliance 1/20/17 | |

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facility's smoking policy, the need to report noncompliance to a supervisor and training in RACE. The video showed how to use a fire extinguisher. The video did not show how to use a fire blanket or what to do if a resident was on fire, just what to do if a resident room or building was on fire.

On 12/20/16 at 1:43 PM the Administrator stated that if a resident was on fire, she expected staff to do the best they could and assist the best they could. She stated that she was not sure if a fire extinguisher should be used on a person and the fire blanket could be used depending on the size of the fire. The Administrator stated that NA #1 calling 911 was extremely important and that she felt the nurse aide did what she could in that situation. The administrator supported the NA in her decision to leave the resident to get help and call 911.

A phone interview with the local fire marshal on 12/20/16 at 3:04 PM revealed that his first choice would have been to use a fire blanket to smother the fire. He further stated that the likelihood of oxygen gathering in a pocket under the blanket creating a possible explosion would be unlikely and mostly control the fire.

Phone interview with the Battalion Chief of the responding emergency response team conducted on 12/20/16 at 3:14 PM revealed that using a blanket over the resident with oxygen flowing would have smothered the fire.

Interview with the Maintenance Supervisor on 12/20/16 at 3:30 PM revealed that he trained all new employees on the location of fire alarms, fire extinguishers and fire blanket. He stated there

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had been 2 paper signs located in plastic sleeves at the gazebo area stating this was a smoking area and no oxygen was allowed. He stated he did not review with employees how to use a fire blanket.

Nurse #2 was interviewed on 12/20/16 at 4:47 PM. Nurse #2 stated she responded to NA #1 alerting staff she had seen him on fire. Nurse #1 stated they found him back in his room giving himself a breathing treatment she had left ready for him. She stated his upper lip and under his nose was blackened and the oxygen tubing had melted on his cheek.

The Administrator and Director of Nursing were informed of immediate jeopardy on 12/20/16 at 4:37 PM.

The facility provided an acceptable allegation of compliance on 12/21/16 at 1:51 PM as follows:

1. On 12/6/16 at approximately 8:30pm Resident #2 was observed sitting outside the 400 Hall Door near the Resident and Staff smoking area by NA #1 who was exiting the facility, she did not notice if Resident #2 was smoking. NA #1 walked past Resident #2 to the staff smoking area less than 10 feet away, as she turned to sit down at the picnic table she noticed flames at Resident #2's face and hands. NA #1 immediately noticed that Resident #2 had an oxygen tank on his wheelchair and a cannula in his nares, she attempted to turn off the Oxygen at the regulator but Resident #2 was flailing his arms and had positioned himself with the back of the wheelchair against the door and she was unable to reach the regulator. She was also unable to re-enter the facility for help because the wheelchair was

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blocking the door. NA #1 was reluctant to cover the resident with the Fire Blanket for fear of trapping more oxygen and worsening the flames. NA #1 then ran around the left corner of the facility and called 911 on her cell phone as she was running to the front door of the facility for help. As she entered the facility she notified the Charge Nurse #1 and the Supervisor #1. Charge Nurse #1 immediately ran to the 400 Hall Door and Resident #2 was no longer located there, he had extinguished the flames and returned to his Resident Room # 207. As the Charge Nurse #1 entered the Resident Room #207 she noticed Resident #2 had applied his nebulizer mask and started a nebulizer treatment, he stated "I am fine, just need to finish my breathing treatment." Charge Nurse #1 and Supervisor #1 immediately removed the mask and began to assess Resident #2 for injuries. Observations included black soot to the lower half of his face and singed hair on the left side of his head and surrounding his face. The Fire Department and the Emergency Medical Services arrived and immediately transported Resident #2 to the Emergency Room, where he was admitted in stable condition to the ICU for observation of burns to the nasal area and respiratory monitoring. On 12/6/16 Supervisor #1 notified Resident #2's responsible party, the On Call Physician, the Facility Medical Director, the Facility Administrator and the Facility Director of Nursing.

On 12/20/16 NA #1 received one on one education by the Director of Nursing to include the facility's policy regarding Fire Management, Fire Extinguisher usage, the use of a Fire Blanket to extinguish a personal fire, turning off any Oxygen in use during a fire, and to supervise and attend to a resident during an emergency

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situation by not leaving the resident until further assistance has arrived.

2. Current residents have the potential to be affected by this same alleged deficient practice.

By 12/8/16 the Director of Nursing and Assistant Director of Nursing educated all Facility staff including Administration, Nursing, Therapy, Housekeeping and Dietary regarding the Facility Policy for Safe Smoking to include the following:

- Location and use of safety equipment in this area including the fire blanket, the fire extinguisher and ashtrays and receptacles.

On 12/20/16 an updated educational plan was developed by the Interdisciplinary Team consisting of the Administrator, Director of Nursing, Social Services, Director of Rehab, Director of Housekeeping and Director of Dietary Services on to include Facility specific policy and procedures for Fire Management and Smoking that address Oxygen is prohibited in designated smoking areas.

On 12/20/16 this Fire Safety educational plan was reviewed and further developed by the Administrator, Director of Nursing and the Area Staff Development Director with assistance from the District Field Support Team. This review included involvement with the local Fire Marshall who reviewed and accepted this plan.

On 12/20/16 all facility staff including Administration, Nursing, Therapy, Housekeeping and Dietary by the Administrator, Director of Nursing, Area Staff Development Director and Nurse Managers received this updated education

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to include:

-The Facility policy and procedures for Fire Management, Smoking and that Oxygen is not prohibited in designated smoking areas.
-Fire Extinguisher usage to include the Pull, Aim, Squeeze and Sweep method for effective fire extinguishing as outlined in the facility policy for Fire Management.
-Use of a Fire Blanket to cover and smother flames to manage a personal fire as outlined in the facility policy for Fire Management.
-Discontinuing any Oxygen in use and removing the tank as soon as possible during a fire as outlined by the facility policy for Fire Management.
-Supervise and attend to a Resident during an emergency situation by not leaving the resident until further assistance has arrived.

The Administrator and Director of Nursing will oversee the ongoing implementation of this updated educational plan for completion and effectiveness during orientation and annual training based on observations and ongoing participation in training sessions. Monthly observation of education and return demonstration by staff during educational sessions will be observed and completed by the Administrator and Director of Nursing to validate the effectiveness of education for 6 months. Fire Drills will be conducted monthly by the Maintenance Director with oversight from the Administrator and Director of Nursing to further validate compliance.

Ongoing education will include additional Fire Safety training for all facility staff provided by the local Fire Marshall to be completed by January

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15, 2017. This education will include:

-General Fire Safety with a video presentation
-When and How to correctly use a Fire Extinguisher
-When and How to correctly use a fire Blanket
-Oxygen precautions with regards to Fire Safety

This training is scheduled on the following dates:

-January 4, 2017 at 7am
-January 5, 2017 at 2:30pm
-January 11, 2017 at 10am
-January 12, 2017 at 3:30pm

The Administrator and Director of Nursing will have no tolerance for noncompliance with the Facility Safe Smoking policies and Fire Safety.

No staff shall work after 12/20/16 before receiving this education. This education has been added to the Facility Orientation program for all new hires and agency staff to be completed prior to beginning work in resident care areas after 12/20/16. Ongoing Fire Safety training will be held annually for all facility staff and more frequently if an opportunity with compliance is identified.

Immediate jeopardy was removed on 12/21/16 at 3:26 PM when interviews with nursing staff, administrative staff, and non-nursing staff confirmed they had received training on the facility's procedure to correctly use a fire extinguisher, correctly use a fire blanket, discontinue oxygen if in use and stay with a resident involved until help arrived. Verification of staff training was reviewed, appropriate signage was observed in the designated area, 24 hour

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| F 518 | Continued From page 44<br>monitoring of the smoking are, storage for oxygen tanks outside the smoking area and storage of smoking materials was observed in place. | F 518 | | |