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E 013 SS=J	Development of EP Policies and Procedures CFR(s): 483.73(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.542(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must	E 013		2/6/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 02/01/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 013	Continued From page 1 address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Emergency Medical Services (EMS) report, review of video surveillance footage and staff, paramedic, and hospital Attending Physicians/Nurse/Physician Assistant/receptionist interviews, the facility failed to implement emergency procedures after a resident experienced an oxygen explosion when staff did not provide emergency first aid to Resident #1 whereby he sustained second- and third-degree flame burns to both sides of his face, both ears, left chest, left upper arm, left forearm, and back of left hand. Facility staff did not position the resident to facilitate an open airway, attempt to	E 013	This allegation of compliance is submitted in compliance with applicable law and regulation. To demonstrate continuing compliance with applicable law, the center has taken or will take the actions set forth in the following allegation of compliance. The following credible allegations constitutes the center□s allegation of compliance. All alleged deficiencies have been or will be completed by the dates indicated. E013 1. Identify those recipients who have	

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provide oxygen to an oxygen dependent resident, or attempt to provide covering for a resident when the recorded low temperature for 1/7/23 was 29-degrees Fahrenheit. When EMS arrived, they observed Resident #1 slumped over sitting in a wheelchair, unresponsive and without a pulse or respirations. EMS personnel immediately began cardiopulmonary resuscitation (CPR) once inside the ambulance. He went into cardiac arrest twice, was intubated, and became comatose. Resident #1 expired on 01/12/23. This deficient practice occurred for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #1).

Immediate jeopardy began on 01/07/23 when the facility failed to implement their emergency preparedness plan. Immediate jeopardy was removed on 01/14/23 when the facility provided an acceptable credible allegation for immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of "D" (No actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure completion of education and monitoring systems put into place are effective.

Findings included:

Documentation on the Nursing Policies and Procedures manual, a part of the facility's Emergency Preparedness plan, dated 10/26/22 included the following policy: "A licensed nurse will provide emergency first aid as indicated by the situation to anyone in the center experiencing an accident or incident." Procedures included: "Emergency first aid may include but is not limited to: CPR [cardiopulmonary resuscitation], Rescue breathing, control of bleeding/hemorrhage, administration of emergency oxygen, application

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suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and

Resident #1 no longer resides in the center. On 1/7/23, shortly before 3AM, Resident #1 was noted in doorway of his room as the Night Shift Supervisor was coming down the hall. She could see that smoke was coming from the room. She began to call his name and as she approached him, she could see his hair was singed. As she got closer, she called his name, and he did not answer as his head was down. She pushed his head up and back and noted his face was melted off referring to his burned face.
She immediately closed his door given the smoke detector was sounding and there was visible smoke, rescued him from danger to the nurse's station, immediately pulled the fire alarm and called 911 for Emergency Medical Services (EMS) and Fire Rescue at 2:56am. While on the phone with 911, the Night Shift Supervisor assessed respirations and pulse and provided the information to dispatch as instructed. The 911 dispatcher asked her to get him to the front of the building to await pickup. The Night Shift Supervisor instructed the certified nurse aide (CNA) to take him to the front of the building to await EMS at the request of the 911 dispatch. In the meantime, the Night Shift Supervisor was asked to stay on the phone with the dispatcher. Other staff initiated the fire plan, to include evacuation of immediate area, and use of fire extinguisher to extinguish smoke in

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of pressure dressings and/or bandages, cleansing of wounds, immobilization of fractures."

Resident #1 was admitted to the facility on 12/29/22 with multiple diagnoses that included Chronic Obstructive Pulmonary Disease, respiratory failure, heart failure, and tobacco use.

Resident #1 was designated as being a Full Code.

A physician's order dated 12/29/22 indicated Resident #1 was to receive oxygen at 4 liters per minute via nasal cannula every day and night shift.

The nursing note written by the Night Shift Supervisor in the electronic medical record of Resident #1 dated 01/07/23 at 3:15 AM stated, "Resident found unresponsive and breathing in front of room door in W/C [wheelchair] with burns to face and hair. Transferred to nurses' station and called 911. Instructed by 911 to bring resident to front of building by EMS and transferred care to EMS."

An interview was conducted with the Night Shift Supervisor on 01/09/23 at 10:30 AM. Night Shift Supervisor stated at about 3:00 AM on 01/07/23 she was sitting at the nurses' station when she heard "an annoying beeping sound," which she later discovered it was the room's smoke detector going off. She got up to investigate the noise. As she walked down the hall, she saw and smelled gray smoke coming from Resident #1's room. She yelled "I know you're not smoking!" to Resident #1. When she reached Resident #1, she saw him in the doorway of his room, sitting upright, with his head down. She lifted his head

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the patient□s room, until the fire department arrived.
During the wait for EMS to arrive, the CNA states she and other staff watched him, took his pulse, and she and other staff continued to speak to him and touch him to reassure him knowing he was unresponsive. His body was severely slumped over in the chair at his torso.
The CNA notes on interview that she and other staff handed him off to EMS upon their arrival at 3:02am. They dismissed themselves when EMS took over.
Administration, to include Administrator, Director of Nursing, Chief Nursing Officer, Medical Officer and VP of Operations reviewed the facility□s emergency preparedness plan which includes the Fire Plan on 1/12/23 and determined the facility did not implement the plan in that a nurse failed to provide direct care monitoring of Resident #1 until arrival of EMS for six minutes. The nurse that responded initially and the staff that assisted him after he left the unit to go the front of the building failed to monitor and assess Resident #1 who had been through a traumatic event suffering multiple burns. They did not assess him fully to know what nursing and medical needs he had, did not position the resident to promote breathing, did not cover the resident in 30-degree weather outside, and did not provide basic necessary services until EMS arrived.
The nurse further sent him to the lobby with an unlicensed staff member who was unable to monitor him which was required per policy. There were no revisions to the

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and noticed Resident #1's face and hair severely burned, he was breathing, and unresponsive. She described his facial burns as "it was like his face melted off." She immediately brought Resident #1 into the hallway via his wheelchair and closed the door. She pushed him to the nurses' station, pulled the fire alarm, and called 911. She stated she was instructed by 911 to escort Resident #1 to the front of the building and to stay on the phone. She instructed Nursing Assistant #1 (NA) to push Resident #1 to the front of the building. She stated she had checked Resident #1 for a pulse and respirations but could not remember the rate. She stated his pulse was strong, and his breathing was normal. She stated she did not indicate to other staff to stay with Resident #1 because she was worried about evacuating the other residents.

A review of the video surveillance footage on 01/07/23 revealed Resident #1 was being assisted outside by three staff members. Resident #1 was in a wheelchair, slouched, with his chest to his knees, and arms dangling off the sides of the wheelchair, limp, with no movement. Once outside, two of the staff members stepped away. One staff member remained behind Resident #1. One staff member who stepped to the side, returned to Resident #1. She crouched down, looked at Resident #1's face, stood up, and intermittently touched him. Four additional staff members exited the building and walked past Resident #1. Resident #1 remained sitting in the wheelchair, slouched, with his chest to his knees, and arms dangling off the sides of the wheelchair, limp, with no movement until EMS arrived. He did not have a blanket or jacket to provide protection from cold temperature.

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emergency plan required.

2. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

Education on the emergency preparedness plan, specifically the Fire Plan, began to all staff on 1/12/23 by the DON or designee. This education included:
" First response in area of smoke or fire, to include rescuing patients from smoke or fire.
" Containing and/or extinguishing the fire/smoke
" Use of fire extinguishers
" Departmental Instructions for Fire Plan
¿ provides guidance and responsibilities to each department in the event of a fire, smoke, and/or evacuation needs.
¿ Licensed nurses are to provide direct assistance to patients within the fire plan and departmental designations, which would follow the policy for Emergency First Aide, Nursing Policy 1101.
" Provision of emergency first aide as indicated by the situation to anyone in the center experiencing an accident or incident.
" A licensed nurse will assess injured persons, obtain vitals, monitor patient for changes. Obtain vital signs, pulse ox etc. as condition warrants.
" In the case of burn, protect airway, such as positioning, rescue breathing,

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According to www.accuweather.com, the low temperature was 29-degrees Fahrenheit on 1/07/23 in Burlington.

An interview with NA #1 on 01/09/23 at 3:36 PM revealed she was not assigned to work with Resident #1 on 01/07/23. She responded to the fire alarm sound and when she arrived at the nurses' station, she was instructed by the Night Shift Supervisor to bring Resident #1 to the outside front of the building. She indicated she saw Resident #1's injuries and described them as "his skin was peeled off his face and his hair was burned on the side." She indicated she was not given other instructions from the Night Shift Supervisor regarding providing aid to Resident #1.

Nurse #1 was interviewed on 01/22/23 at 2:58 PM. She indicated she was assigned to work with Resident #1 on 01/07/23 and knew Resident #1 was dependent on oxygen. She indicated she was not on the floor when the incident occurred. She went to the front of the building because she was notified by other staff members Resident #1 had burned himself while smoking a cigarette. When she had arrived at the front of the building, EMS had already arrived. She indicated when she saw Resident #1, his head was down, and he was unresponsive. She did not assess Resident #1 because EMS had already arrived. Later in the interview, she stated the first time she checked Resident #1 for a pulse and respirations was when he was outside front of the building. She took his pulse and respirations manually and noted his breathing was shallow and his pulse was strong and within normal range. She stated she could not remember the pulse or respiration rates. She indicated she was not provided any

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CPR, emergency oxygen
" Providing emergency first aide for other accidents/incidents as needed-CPR, Rescue breathing, control bleeding, emergency oxygen, cleansing wounds/applying dressing, immobilizing fractures.
" Consider weather and need for covering should patient be taken outside
" Notification to physician/Next of Kin as soon as possible.
" Contacting EMS
" Assuring that licensed staff attend resident until EMS arrives, continue to monitor, assess and intervene as needed
" Completion of documentation related to the incident

Any staff member that did not receive education on 1/12/23 will receive education by the beginning of the next shift by the DON or designee. All new hire licensed staff will be educated by the Staff Development Coordinator (SDC) on this policy. The Staff Development Coordinator will retain the master log of those who continued to need education, to assure all staff are educated on the emergency preparedness plan, specifically the fire plan and departmental responsibilities.
" The DON or designee will verify the understanding of the education through oral discussion and feedback with all staff and notate this on a tracking tool. The SDC will also do this in orientation. Licensed nurses will complete a post-test for their education on Nursing Policy 1101. Post-test will begin on 01/13/2023. SDC

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instructions regarding providing aid to Resident #1 and did not indicate why she had not stayed with Resident #1.

NA #3 was interviewed on 01/10/23 at 10:25 AM. She indicated she was assigned to work with Resident #1 on 01/07/23, was familiar with his care needs, and knew he was oxygen dependent. She stated she had checked 10 to 15 minutes prior to the incident. She indicated she was outside of the building and was not on the floor when the incident occurred. The first time she saw Resident #1 after the incident was when he was outside on the stretcher with EMS.

Documentation of the Emergency Medical Services (EMS) report dated 01/07/23 revealed at 3:01 AM, EMS arrived on scene. Resident #1 was sitting in a wheelchair outside of the front door of the facility. Resident #1 was noted to be slouched/slumped over in the wheelchair. Staff was immediately asked if the resident was breathing and if the resident had a pulse. The nursing staff responded, "he's unconscious." EMS personnel, again, asked if the resident was breathing and if he had a pulse, "to which the nursing staff did not check the patient." EMS noted all nursing staff had no hands on the resident, the resident was not being assessed, nor was treatment administered by nursing staff prior to EMS arrival. EMS personnel quickly assessed the resident. The resident was found to not be breathing or have a pulse. EMS personnel asked the nursing staff about Resident #1's information and paperwork, and the staff responded with "we don't know anything about the patient, and there is a fire, so we can not [sic] get you that information." It was noted that nursing staff continued to enter and exit the front

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will conduct the testing.

" A fire drill will occur on all each 12-hour shifts beginning on 1/13/23, which will include the provision of services to an injured patient from smoke inhalation/burns, for response, further education needed, and confirmation of education understood. This will be conducted by Maintenance Director, SDC, and Director of Nursing.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
In addition to the education above, the Facility Administrator, DON, Maintenance Director and/or designee will conduct emergency simulation events weekly x `8 weeks, then twice monthly x1 month to ensure compliance is achieved I the area of emergency response.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;
The Administrator will be responsible for the findings from the audits and will report to the Quality Assurance Performance Improvement (QAPI) committee for recommendations and/or modifications until a pattern of compliance is achieved. The Administrator is responsible for the entire plan of correction.

5. Date of completion 2/06/2023

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doors of the facility.

An interview was conducted with the responding Paramedic on 01/11/23 at 12:29 PM. The Paramedic stated when he arrived, he saw Resident #1 slumped over in a wheelchair outside in front of the facility. Resident #1 did not look like he was breathing. There were staff members around Resident #1; however, no staff member hand their hands on Resident #1. He stated staff members were either on their phones or walking around. He further indicated staff members could not report if Resident #1 was breathing or had a pulse. He also stated facility staff was not able to provide him Resident #1's name, date of birth, or medical conditions. When he assessed Resident #1 it was determined Resident #1 did not have a pulse or respirations. Resident #1 was assessed to the stretcher via 2-person manual lift and cardiopulmonary resuscitation (CPR) was started in the ambulance.

The Emergency Room hospital records indicated Resident #1 presented to the hospital with partial-thickness burns covering Resident #1's face and neck as well as clavicle and shoulder, approximately 10% of body surface area, and soot in the nostrils. The Emergency Room physician noted EMS reported Resident #1 was sitting in wheelchair with oxygen on via nasal cannula when he subsequently lit a cigarette that exploded in his face causing severe burns to the face, neck, shoulders, and clavicle. Resident #1 was noted to be unresponsive, without a pulse so CPR was initiated by EMS. CPR was performed for 30 minutes then his pulse and blood pressure returned. Resident #1 went into cardiac arrest again for several minutes and was intubated after his pulse and blood pressure returned for the

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second time. Due to his significant burns, the hospital initiated a transfer to a local burn unit.

A review of the Burn Attending Intensive Care Unit (ICU) hospital note dated 01/07/23 revealed Resident #1 was critically ill and sustained second- and third-degree flame burns to both sides of his face, both ears, left chest, left upper arm, left forearm, and back of left hand to 5.5% of his body. It was noted that he also went into cardiac arrest twice as well has having acute respiratory failure secondary to pulmonary edema (excess fluid in the lungs) and aspiration.

An interview with ICU Nurse #1 was conducted on 01/09/23 at 3:02 PM. She indicated Resident #1 was comatose, intubated, unable to speak, and had an anoxic brain injury (a brain injury caused by a complete lack of oxygen to the brain). Resident #1's code status was switched from Full Code to Do Not Resuscitate (DNR).

The ICU Physician Assistant was interviewed on 01/10/23 at 12:32 PM. She indicated it was reported to her that Resident #1 was smoking at the facility and caught fire. He was found to be unresponsive and remained unresponsive since admission to the ICU burn unit. She stated his injuries were consistent with smoking while on oxygen.

The ICU Attending Physician was interviewed on 01/11/23 at 9:39 AM via phone revealed at the time of the call, Resident #1 had an anoxic brain injury (brain injury which occurs due to lack of oxygen to the brain) and had a poor prognosis. He was intubated, in critical condition, and unresponsive. She indicated she did not expect a full recovery and a palliative care consult would

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be placed due to Resident #1's poor prognosis.

An interview with ICU Nurse #2 was conducted on 01/12/23 at 3:51 PM. She indicated Resident #1 remained in critical condition. Resident #1 was placed on comfort care with no aggressive treatment. He was not expected to recover, and death was imminent.

On 01/19/23 at 12:34 PM the ICU Receptionist was interviewed. She indicated Resident #1 died on 01/12/23 at 5:15 PM.

The Director of Nursing (DON) was interviewed on 01/09/22 at 1:57 PM. She stated she received a call from a staff member around 3:00 AM on 1/07/22 notifying her of Resident #1 sustaining injuries from lighting a cigarette while on oxygen. She indicated she did not see Resident #1 when she arrived at the facility as he had already been taken by ambulance; therefore, she was unable to assess Resident #1. She indicated she felt the staff responded appropriately to the emergency.

The Administrator was notified of immediate jeopardy January 11, 2023, at 7:35 PM.

The facility provided the following credible allegation for immediate jeopardy removal:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and

On 1/7/23, shortly before 3AM, Resident #1 was noted in doorway of his room as the Night Shift Supervisor was coming down the hall. She could see that smoke was coming from the room. She began to call his name and as she approached

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ALAMANCE HEALTH CARE CENTER	**1987 HILTON ROAD BURLINGTON, NC 27217**

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him, she could see his hair was singed. As she got closer, she called his name, and he did not answer as his head was down. She pushed his head up and back and noted his face was "melted off" referring to his burned face.

She immediately closed his door given the smoke detector was sounding and there was visible smoke, rescued him from danger to the nurses station, immediately pulled the fire alarm and called 911 for Emergency Medical Services (EMS) and Fire Rescue at 2:56am. While on the phone with 911, the Night Shift Supervisor assessed respirations and pulse and provided the information to dispatch as instructed. The 911 dispatcher asked her to get him to the front of the building to await pickup. The Night Shift Supervisor instructed the certified nurse aide (CNA) to take him to the front of the building to await EMS at the request of the 911 dispatch. In the meantime, the Night Shift Supervisor was asked to stay on the phone with the dispatcher. Other staff initiated the fire plan, to include evacuation of immediate area, and use of fire extinguisher to extinguish smoke in the patient's room, until the fire department arrived.

During the wait for EMS to arrive, the CNA states she and other staff watched him, took his pulse, and she and other staff continued to speak to him and touch him to reassure him knowing he was unresponsive. His body was severely slumped over in the chair at his torso. The CNA notes on interview that she and other staff handed him off to EMS upon their arrival at 3:02am. They dismissed themselves when EMS took over.

Administration, to include Administrator, Director of Nursing, Chief Nursing Officer, Medical Officer

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and VP of Operations reviewed the facility's emergency preparedness plan which includes the Fire Plan on 1/12/23 and determined the facility did not implement the plan in that a nurse failed to provide direct care monitoring of Resident #1 until arrival of EMS for six minutes. The nurse that responded initially and the staff that assisted him after he left the unit to go the front of the building failed to monitor and assess Resident #1 who had been through a traumatic event suffering multiple burns. They did not assess him fully to know what nursing and medical needs he had, did not position the resident to promote breathing, did not cover the resident in 29-degree weather outside, and did not provide basic necessary services until EMS arrived. The nurse further sent him to the lobby with an unlicensed staff member who was unable to monitor him which was required per policy. There were no revisions to the emergency plan required.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

o Education on the emergency preparedness plan, specifically the Fire Plan, began to all staff on 1/12/23 by the DON or designee. This education included:
o First response in area of smoke or fire, to include rescuing patients from smoke or fire.
o Containing and/or extinguishing the fire/smoke
o Use of fire extinguishers
o Departmental Instructions for Fire Plan
o provides guidance and responsibilities to each department in the event of a fire, smoke, and/or evacuation needs.

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o Licensed nurses are to provide direct assistance to patients within the fire plan and departmental designations, which would follow the policy for Emergency First Aide, Nursing Policy 1101.
o Provision of emergency first aide as indicated by the situation to anyone in the center experiencing an accident or incident.
o A licensed nurse will assess injured persons, obtain vitals, monitor patient for changes. Obtain vital signs, pulse ox etc. as condition warrants.
o In the case of burn, protect airway, such as positioning, rescue breathing, CPR, emergency oxygen
o Providing emergency first aide for other accidents/incidents as needed-CPR, Rescue breathing, control bleeding, emergency oxygen, cleansing wounds/applying dressing, immobilizing fractures.
o Consider weather and need for covering should patient be taken outside
o Notification to physician/Next of Kin as soon as possible.
o Contacting EMS
o Assuring that licensed staff attend resident until EMS arrives, continue to monitor, assess and intervene as needed
o Completion of documentation related to the incident

o Any staff member that did not receive education on 1/12/23 will receive education by the beginning of the next shift by the DON or designee. All new hire licensed staff will be educated by the Staff Development Coordinator (SDC) on this policy. The Staff Development Coordinator will retain the master log of those who continued to need education, to assure all staff are educated on the emergency

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preparedness plan, specifically the fire plan and departmental responsibilities.

o The DON or designee will verify the understanding of the education through oral discussion and feedback with all staff and notate this on a tracking tool. The SDC will also do this in orientation. Licensed nurses will complete a post-test for their education on Nursing Policy 1101. Post-test will begin on 01/13/2023. SDC will conduct the testing.

o A fire drill will occur on all three shifts beginning on 1/13/23, which will include the provision of services to an injured patient from smoke inhalation/burns, for response, further education needed, and confirmation of education understood. This will be conducted by Maintenance Director, SDC, and Director of Nursing.

IJ removal date is January 14, 2023.

Person responsible for implementation is the administrator.

On 01/17/23, the facility's credible allegation for immediate jeopardy removal was validated by record review of in-services; multiple interviews with facility staff revealed they received education on the facility's policies regarding responding to smoke or fire, fire extinguishers, and fire plan; documentation review and interview with the Maintenance Director regarding a fire drill conducted on 01/15/23; and interviews with the Staff Development Coordinator, Director of Nursing, and Administrator regarding the mandatory education. Immediate jeopardy was removed on 01/14/23.

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F 000	INITIAL COMMENTS	F 000		

A complaint investigation survey was conducted on 01/09/2023 through 01/17/2023. One of two complaint allegations were substantiated. Intakes NC00196780 and NC00196991 were investigated. Intake NC00196780 resulted in immediate jeopardy. Event ID # T2J111. Immediate Jeopardy was identified at:

CFR 483.12 at tag F600 at a scope and severity J
CFR 483.25 at tag F684 at a scope and severity J
CFR.483.25 at tag F689 at a scope and severity J
CFR 483.73 at tag E0013 at a scope and severity J

The tags F600, F684, and F689 constituted Substandard Quality of Care.

Immediate Jeopardy began on 01/06/23 and ended on 01/17/23.

A partial extended survey was conducted on 01/17/23.

All references to a video in this CMS 2567 are from a video of a video that the facility provided to the state agency on January 12, 2023 at 5:22 pm.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION DATE
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)	F 550		2/6/23

§483.10(a) Resident Rights.
The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

§483.10(a)(1) A facility must treat each resident

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with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, review of facility surveillance video, and staff interviews the facility failed to treat a resident in a dignified manner when facility staff wheeled Resident #1 out the front door of the facility slumped over in his wheelchair to wait for Emergency Medical

F 550

F550

1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and

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Services (EMS) after he sustained significant second and third degree burns to his face, both ears, left side of chest, left upper arm, left forearm, and back of left hand. Resident #1 was unconscious and remained slumped over in his wheelchair wearing only a short-sleeved T-shirt and pajama bottoms when the lowest temperature was recorded to be 29-degrees Fahrenheit on accuweather.com while waiting for EMS for 1 of 1 resident reviewed for dignity (Resident #1).

The findings included:

Resident #1 was admitted to the facility on 12/29/22 with multiple diagnoses which included Chronic Obstructive Pulmonary Disease, respiratory failure, peripheral vascular disease, heart failure, tobacco use.

The nursing note written by the Night Shift Supervisor in the electronic medical record of Resident #1 dated 01/07/23 at 3:15 AM stated, "Resident found unresponsive and breathing in front of room door in W/C [wheelchair] with burns to face and hair. Transferred to nurses' station and called 911. Instructed by 911 to bring resident to front of building by EMS and transferred care to EMS."

An interview was conducted with the Night Shift Supervisor on 01/09/23 at 10:30 AM. Night Shift Supervisor stated at about 3:00 AM on 01/07/23 she was sitting at the nurses' station when she heard "an annoying beeping sound," which she later discovered it was the room's smoke alarm going off. She got up to investigate the noise. As she walked down the hall, she saw and smelled gray smoke coming from Resident #1's room.

F 550

Resident #1 no longer resides in the facility. All residents have the potential to be affected by the same deficient practice.
2. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.
Education was provided by the Staff Development Coordinator on 1/27/23 to all staff regarding resident rights, dignity and what constitutes dignity, including assuring residents are properly clothed related to weather conditions, and properly positioned to receive care and treatment. Staff will be instructed to report any alleged violations of resident rights and/or dignity as part of the education. Any staff that were not educated by 1/27/23 will receive education by their next shift. Education on resident rights and dignity will continue to occur as part of the center orientation.
All current residents will be interviewed regarding dignity and respect using a questionnaire by 02/05/23 to determine if there are any alleged violations of dignity as self-reported by patients. Follow-up will occur to include facility investigation and external reporting as needed.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
Monitoring will include use of the same questionnaire to residents, to interview 15 residents weekly x 4 weeks, then biweekly x 4 weeks, then monthly x1. This will be

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When she reached Resident #1, she saw him in the doorway of his room, sitting upright, with his head down. She lifted his head and noticed Resident #1's face and hair severely burned, he was breathing, and unresponsive. She described his facial burns as "it was like his face melted off." She immediately brought Resident #1 into the hallway via his wheelchair and closed the door. She pushed him to the nurses' station, pulled the fire alarm, and called 911. She stated she was instructed by 911 to escort Resident #1 to the front of the building and to stay on the phone. She instructed Nursing Assistant #1 (NA) to push Resident #1 to the front of the building and did not provide any further instructions to NA #1.

A review of the video surveillance footage on 01/07/23 revealed Resident #1 was being assisted outside by three staff members. Resident #1 was in a wheelchair, slouched, with his chest to his knees, and arms dangling off the sides of the wheelchair, limp, with no movement. Once outside, two of the staff members stepped away. One staff member remained behind Resident #1. One staff member who stepped to the side, returned to Resident #1. She crouched down, looked at Resident #1's face, stood up, and intermittently touched him. Four additional staff members exited the building and walked past Resident #1. Resident #1 remained sitting in the wheelchair, slouched, with his chest to his knees, and arms dangling off the sides of the wheelchair, limp, with no movement until EMS arrived. He did not have a blanket or jacket to provide protection from the 29-degree Fahrenheit temperature.

An interview with NA #1 on 01/09/23 at 3:36 PM revealed she was not assigned to work with

F 550

completed by the DON, Director of Social Work or designee. Any identified issues will be addressed immediately with investigation and external reporting as needed.
4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;
The Administrator will be responsible for information that is reported to the Quality Assurance Performance Improvement (QAPI) committee for recommendations and/or modifications until a pattern of compliance is achieved.
The Administrator is responsible for the entire plan of correction

5. Date of completion: 2/06/2023

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F 550	Continued From page 18 Resident #1 on 01/07/23. She responded to the fire alarm sound and when she arrived at the nurses' station, she was instructed by the Night Shift Supervisor to bring Resident #1 to the outside front of the building. She indicated she saw Resident #1's injuries and described them as "his skin was peeled off his face and his hair was burned on the side." Resident #1 was wearing a short sleeve shirt and pajama bottoms. She indicated she was not given other instructions from the Night Shift Supervisor regarding providing aid to Resident #1. She could not recall what Resident #1 was wearing. She further stated she could not remember if she provided Resident #1 with a covering to protect him from the 37-degree Fahrenheit temperature.	F 550		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, review of video surveillance footage and Emergency Medical	F 600	F600 1. Identify those recipients who have	2/6/23

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Service (EMS) report and staff, paramedic and hospital staff interviews, the facility staff neglected to provide necessary services after a resident experienced an oxygen explosion and sustained second- and third-degree flame burns to both sides of his face, both ears, left chest, left upper arm, left forearm, and back of left hand. Resident #1 was unconscious and slumped over in his wheelchair when he was wheeled out of the facility. Facility staff moved by and stood adjacent to the resident and failed to position the resident to facilitate an open airway or render any assistance. When EMS arrived, Resident #1 remained slumped over in a wheelchair, unresponsive, and without a pulse or respirations. Resident #1 went into cardiac arrest twice before arriving at the hospital, required intubation, and became comatose due to his injuries. Resident #1 expired on 01/12/23. This is evidenced for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #1).

Immediate jeopardy began on 01/07/23 when the facility staff neglected to provide necessary services to Resident #1 after he sustained third degree burns to both sides of his face, both of his ears and second degrees burns on his left chest, upper left arm, left forearm, and back of left hand. He was wheeled out of the facility unconscious and slumped over in his wheelchair and facility staff moved by and stood adjacent to the resident with attempting to open his airway or render any assistance. Immediate jeopardy was removed on 01/14/23 when the facility provided an acceptable credible allegation for immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of "D" (No actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure

F 600

suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and
Resident #1 no longer resides in the center. The facility failed to provide care and services to Resident #1 after he had sustained significant facial injuries, as well as 2nd and 3rd degree burns. Resident #1 was unresponsive and was wheeled outside slumped over in his wheelchair. No attempts were made to maintain an open airway or assess the resident for nursing or medical needs.
On 1/7/23, shortly before 3AM, Resident #1 was noted in doorway of his room as the Night Shift Supervisor was coming down the hall. She could see that smoke was coming from the room. She began to call his name and as she approached him, she could see his hair was singed. As she got closer, she called his name, and he did not answer as his head was down. She pushed his head up and back and noted his face was melted off referring to his burned face.
She immediately closed his door given the smoke detector was sounding and there was visible smoke, rescued him from danger to the nurse's station, immediately pulled the fire alarm and called 911 for Emergency Medical Services (EMS) and Fire Rescue at 2:56am. While on the phone with 911, the Night Shift Supervisor assessed respirations and pulse and provided the information to dispatch as instructed. The 911 dispatcher asked her to get him to the front of the building to await pickup. The Night Shift Supervisor instructed the certified nurse aide (CNA)

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completion of education and monitoring systems put into place are effective.

Findings included:

Cross Refer to F684:

Based on record review, review of video surveillance footage and Emergency Medical Service (EMS) report and staff, paramedic and hospital Attending Physicians/Nurse/Physician Assistant/receptionist interviews, the facility failed to identify the seriousness of 3rd degree facial burns when staff did not provide continuous monitoring of Resident #1's vital signs or assess the resident to determine the need for nursing or medical interventions until Emergency Medical Services arrived. Resident #1 sustained second and third degree burns to his face, both ears, left side of chest, left upper arm, left forearm, and back of left hand. Additionally, the low outdoor temperature on 01/07/23 was recorded as 29-degrees Fahrenheit, and Resident #1 was only wearing thin pajama pants and a short sleeve shirt while outside. Resident #1 was described by EMS records as being "slouched/slumped over in his wheelchair" when they arrived, and he was pulseless and not breathing. EMS personnel immediately began cardiopulmonary resuscitation (CPR) inside the ambulance. Resident #1 went into cardiac arrest, required intubation, and became comatose due to his injuries. This deficient practice occurred for 1 of 3 residents reviewed for supervision to prevent accidents.

The Administrator was notified of immediate jeopardy on January 13, 2023, at 10:50 AM.

The facility provided the following credible

F 600

to take him to the front of the building to await EMS at the request of the 911 dispatch. In the meantime, the Night Shift Supervisor was asked to stay on the phone with the dispatcher. However, the nurse did not provide instruction to the certified nurse aide as to what to do for this resident; she didn□t assess what the resident needed and failed to render emergency care to maintain Resident # 1□s airway.
During the wait for EMS to arrive, the CNA states she and other staff watched him, took his pulse, and she and other staff continued to speak to him and touch him to reassure him knowing he was unresponsive. His body was severely slumped over in the chair at his torso.
The CNA notes on interview that she and other staff handed him off to EMS upon their arrival at 3:02am. They dismissed themselves when EMS took over.
In review of this incident, the nurse and staff assigned to him after he left the unit failed to monitor and assess Resident #1 who had been through a traumatic event suffering multiple burns, did not assess him fully to know what nursing and medical needs he had, did not position the resident to promote breathing, did not cover the resident in 37-degree weather outside, and did not provide basic necessary services until EMS arrived.
The nurse further sent him to the lobby with an unlicensed staff member who was unable to monitor him which was required per policy.

All residents are at risk for neglect.

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allegation for immediate jeopardy removal:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and
The facility failed to provide care and services to Resident #1 after he had sustained significant facial injuries, as well as 2nd and 3rd degree burns. Resident #1 was unresponsive and was wheeled outside slumped over in his wheelchair. No attempts were made to maintain an open airway or assess the resident for nursing or medical needs.

On 1/7/23, shortly before 3AM, Resident #1 was noted in doorway of his room as the Night Shift Supervisor was coming down the hall. She could see that smoke was coming from the room. She began to call his name and as she approached him, she could see his hair was singed. As she got closer, she called his name, and he did not answer as his head was down. She pushed his head up and back and noted his face was "melted off" referring to his burned face.

She immediately closed his door given the smoke detector was sounding and there was visible smoke, rescued him from danger to the nurses station, immediately pulled the fire alarm and called 911 for Emergency Medical Services (EMS) and Fire Rescue at 2:56am. While on the phone with 911, the Night Shift Supervisor assessed respirations and pulse and provided the information to dispatch as instructed. The 911 dispatcher asked her to get him to the front of the building to await pickup. The Night Shift Supervisor instructed the certified nurse aide (CNA) to take him to the front of the building to await EMS at the request of the 911 dispatch. In

F 600

2. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be completed.

Education began for nursing staff to include licensed nurses and nursing assistants on 1/12/23, by the DON or designee. Education included Nursing policy 1110-Emergecy First Aide, and other information noted below. Education included:
" Provision of emergency first aide as indicated by the situation to anyone in the center experiencing an accident or incident.
" A licensed nurse will assess injured persons, obtain vitals, monitor patient for changes. Obtain vital signs, pulse ox etc. as condition warrants.
" In the case of burn, protect airway, such as positioning, rescue breathing, CPR, emergency oxygen.
" Providing emergency first aide for other accidents/incidents as needed-CPR, Rescue breathing, control bleeding, emergency oxygen, cleansing wounds/applying dressing, immobilizing fractures.
" Notification to physician/Next of Kin as soon as possible.
" Contacting EMS
" Assuring that licensed staff attend resident until EMS arrives, continue to monitor, assess and intervene as needed
" Completion of documentation related to the incident

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the meantime, the Night Shift Supervisor was asked to stay on the phone with the dispatcher. However, the nurse did not provide instruction to the certified nurse aide as to what to do for this resident; she didn't assess what the resident needed and failed to render emergency care to maintain Resident # 1's airway.

During the wait for EMS to arrive, the CNA states she and other staff watched him, took his pulse, and she and other staff continued to speak to him and touch him to reassure him knowing he was unresponsive. His body was severely slumped over in the chair at his torso. The CNA notes on interview that she and other staff handed him off to EMS upon their arrival at 3:02am. They dismissed themselves when EMS took over.

In review of this incident, the nurse and staff assigned to him after he left the unit failed to monitor and assess Resident #1 who had been through a traumatic event suffering multiple burns, did not assess him fully to know what nursing and medical needs he had, did not position the resident to promote breathing, did not cover the resident in 30 degree weather outside, and did not provide basic necessary services until EMS arrived. The nurse further sent him to the lobby with an unlicensed staff member who was unable to monitor him which was required per policy.

All residents are at risk for neglect.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be completed.

F 600

Education began for all staff on abuse and neglect began on 01/13/2023 by staff development coordinator. Education included information regarding types of abuse and neglect as referenced in administrative in policy 704 reference guide for reporting, abuse policy 703 reporting requirements for unusual events and occurrences.

Any nursing staff member that did not receive education on 1/12/23 will receive education by the beginning of the next shift by the DON or designee. The Staff Development Coordinator will be responsible for tracking staff that still require education. Any staff that has not received education will not be allowed to work until education is received. All new hire licensed staff will be educated by the Staff Development Coordinator on this policy. This education will be added to the orientation process. Staff Development was notified of this responsibility on 01/12/2023.

The DON or designee will verify the understanding of the education through oral discussion and feedback with all staff and notate this on a tracking tool. The SDC will also do this in orientation.

Nursing staff will complete a post- test based on the education provided. Staff Development Coordinator is responsible for the post test and monitoring the post test results. The posttest is initiated on 01/13/2023.

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Education began for nursing staff to include licensed nurses and nursing assistants on 1/12/23, by the DON or designee. Education included Nursing policy 1110-Emergecy First Aide, and other information noted below.
Education included:
" Provision of emergency first aide as indicated by the situation to anyone in the center experiencing an accident or incident.
" A licensed nurse will assess injured persons, obtain vitals, monitor patient for changes. Obtain vital signs, pulse ox etc. as condition warrants.
" In the case of burn, protect airway, such as positioning, rescue breathing, CPR, emergency oxygen
" Providing emergency first aide for other accidents/incidents as needed-CPR, Rescue breathing, control bleeding, emergency oxygen, cleansing wounds/applying dressing, immobilizing fractures.
" Notification to physician/Next of Kin as soon as possible.
" Contacting EMS
" Assuring that licensed staff attend resident until EMS arrives, continue to monitor, assess and intervene as needed
" Completion of documentation related to the incident

Education began for all staff on abuse and neglect began on 01/13/2023 by staff development coordinator. Education included information regarding types of abuse and neglect as referenced in administrative policy 704.

Any nursing staff member that did not receive education on 1/12/23 will receive education by the beginning of the next shift by the DON or

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3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
The Director of Nursing, Staff Development Coordinator will monitor to include reviewing of all newly hired staff to assure that they have received training for abuse and neglect and have successfully completed a posttest with acceptable passing scoring weekly x 4 weeks, bi-weekly x 1month then monthly x 1 month.
The Administrator is responsible for the entire plan of correction.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;
The Administrator or Designee will be responsible for reporting information from the audits to the Quality Assurance Performance Improvement (QAPI) committee for recommendations and/or modifications until a pattern of compliance is achieved.
The Administrator is responsible for the entire plan of correction.

5. Date of completion: 2/6/2023

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designee. The Staff Development Coordinator will be responsible for tracking staff that still require education. Any staff that has not received education will not be allowed to work until education is received. All new hire licensed staff will be educated by the Staff Development Coordinator on this policy. This education will be added to the orientation process. Staff Development was notified of this responsibility on 01/12/2023.

The DON or designee will verify the understanding of the education through oral discussion and feedback with all staff and notate this on a tracking tool. The SDC will also do this in orientation.

Nursing staff will complete a post- test based on the education provided. Staff Development Coordinator is responsible for the post test and monitoring the post test results. The post test is initiated on 01/13/2023.

Date of immediate jeopardy removal is January 14, 2023

Person responsible for implementation the plan is the Administrator

On 01/17/23, the facility's credible allegation for immediate jeopardy removal was validated by record review of the in-services and sign in sheet which discussed the Nursing Policy - 1110 Emergency First Aid, first aid, and abuse/neglect; multiple staff interviews which indicated education was provided by the Director of Nursing which discussed accidents/incidents (including in case of burns), assessments, notification of physician, cardiopulmonary resuscitation (CPR), emergency

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F 600	Continued From page 25 oxygen, and effective communication; and an interview with the Administrator which indicated the Director of Nursing and Staff Development Coordinator provided mandatory education for all nursing staff. The immediate jeopardy removal date of 1/14/23 was confirmed.	F 600		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, review of video surveillance footage and Emergency Medical Service (EMS) report and staff, paramedic and hospital staff interviews, the facility failed to identify the seriousness of 3rd degree facial burns when staff did not provide continuous monitoring of Resident #1's vital signs or assess the resident to determine the need for nursing or medical interventions until EMS arrived. Resident #1 sustained second- and third-degree flame burns to both sides of his face, both ears, left chest, left upper arm, left forearm, and back of left hand. Additionally, the low outdoor temperature on 01/07/23 was recorded as 29-degrees Fahrenheit, and Resident #1 was only wearing thin pajama pants and a short sleeve shirt while outside. Resident #1 was described by EMS records as being "slouched/slumped over in his	F 684	F684 1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance of provide first aide in a timely manner Resident #1 no longer resides in the center. On 1/7/23, shortly before 3AM, Resident #1 was noted in doorway of his room as the Night Shift Supervisor was coming down the hall. She could see that smoke was coming from the room. She began to call his name and as she approached him, she could see his hair was singed. As she got closer, she called his name, and he did not answer as his head was down. She pushed his head up and back and noted his face was melted	2/6/23

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wheelchair" when they arrived, and he was pulseless and not breathing. EMS personnel immediately began cardiopulmonary resuscitation (CPR) once inside the ambulance. Resident #1 went into cardiac arrest twice, required intubation, and became comatose due to his injuries. Resident #1 expired on 01/12/23. This deficient practice occurred for 1 of 3 residents reviewed for supervision to prevent accidents.

Immediate jeopardy began on 01/07/23 when the facility failed to provide continuous monitoring by staff or assess the resident to determine the need for nursing or medical interventions until Emergency Medical Services arrived. Immediate jeopardy was removed on 01/14/23 when the facility provided an acceptable credible allegation for immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of "D" (No actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure completion of education and monitoring systems put into place are effective.

The findings included:

Resident #1 was admitted to the facility on 12/29/22 with multiple diagnoses which included Chronic Obstructive Pulmonary Disease, respiratory failure, peripheral vascular disease, heart failure, and tobacco use.

A physician's order dated 12/29/22 indicated Resident #1 was to receive oxygen at 4 liters per minute via nasal cannula every day and night shift.

The admission nursing assessment dated 12/29/22 revealed Resident #1 was cognitively

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off referring to his burned face.
She immediately closed his door given the smoke detector was sounding and there was visible smoke, rescued him from danger to the nurse's station, immediately pulled the fire alarm and called 911 for Emergency Medical Services (EMS) and Fire Rescue at 2:56am. While on the phone with 911, the Night Shift Supervisor assessed respirations and pulse and provided the information to dispatch as instructed. The 911 dispatcher asked her to get him to the front of the building to await pickup. The Night Shift Supervisor instructed the certified nurse aide (CNA) to take him to the front of the building to await EMS at the request of the 911 dispatch. In the meantime, the Night Shift Supervisor was asked to stay on the phone with the dispatcher. However, the nurse did not provide instruction to the certified nurse aide as to what to do for this resident; she didn□t assess what the resident needed and failed to render emergency care to maintain Resident # 1□s airway.
During the wait for EMS to arrive, the CNA states she and other staff watched him, took his pulse, and she and other staff continued to speak to him and touch him to reassure him knowing he was unresponsive. His body was severely slumped over in the chair at his torso.
The CNA notes on interview that she and other staff handed him off to EMS upon their arrival at 3:02am. They dismissed themselves when EMS took over.
In review of this incident, the nurse and staff assigned to him after he left the unit

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intact and required supervision with chair/bed-to-transfers.

Resident #1 was designated to be a Full Code.

There was no documentation of vital signs recorded in Resident #1's electronic medical chart for 01/07/23.

The nursing note written by the Night Shift Supervisor in the electronic medical record of Resident #1 dated 01/07/23 at 3:15 AM stated, "Resident found unresponsive and breathing in front of room door in W/C [wheelchair] with burns to face and hair. Transferred to nurses' station and called 911. Instructed by 911 to bring resident to front of building by EMS and transferred care to EMS."

An interview was conducted with the Night Shift Supervisor on 01/09/23 at 10:30 AM. Night Shift Supervisor stated at about 3:00 AM on 01/07/23 she was sitting at the nurses' station when she heard "an annoying beeping sound," which she later discovered it was the room's smoke detector going off. She got up to investigate the noise. As she walked down the hall, she saw and smelled gray smoke coming from Resident #1's room. She yelled "I know you're not smoking!" to Resident #1. When she reached Resident #1, she saw him in the doorway of his room, sitting upright, with his head down. She lifted his head and noticed Resident #1's face and hair severely burned, he was breathing, and unresponsive. She described his facial burns as "it was like his face melted off." She immediately brought Resident #1 into the hallway via his wheelchair and closed the door. She pushed him to the nurses' station, pulled the fire alarm, and called 911. She stated

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failed to monitor and assess Resident #1 who had been through a traumatic event suffering multiple burns, did not assess him fully to know what nursing and medical needs he had, did not position the resident to promote breathing, did not cover the resident in 37-degree weather outside, and did not provide basic necessary services until EMS arrived. The nurse further sent him to the lobby with an unlicensed staff member who was unable to monitor him which was required per policy.

2. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be completed.

Education began for nursing staff to include licensed nurses and nursing assistants on 1/12/23, by the DON or designee. Education included Nursing policy 1110-Emergecy First Aide, and other information noted below. Education included:

" Provision of emergency first aide as indicated by the situation to anyone in the center experiencing an accident or incident.

" A licensed nurse will assess injured persons, obtain vitals, monitor patient for changes. Obtain vital signs, pulse ox etc. as condition warrants.

" In the case of burn, protect airway, such as positioning, rescue breathing, CPR, emergency oxygen

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she was instructed by 911 to escort Resident #1 to the front of the building and to stay on the phone. She instructed Nursing Assistant #1 (NA) to push Resident #1 to the front of the building. She stated she had checked Resident #1 for a pulse and respirations but could not remember the rate. She stated his pulse was strong, and his breathing was normal. She stated she did not indicate to other staff to stay with Resident #1 because she was worried about evacuating the other residents.

A review of the video surveillance footage on 01/07/23 revealed Resident #1 was being assisted outside by three staff members. Resident #1 was in a wheelchair, slouched, with his chest to his knees, and arms dangling off the sides of the wheelchair, limp, with no movement. Once outside, two of the staff members stepped away. One staff member remained behind Resident #1. One staff member who stepped to the side, returned to Resident #1. She crouched down, looked at Resident #1's face, stood up, and intermittently touched him. Four additional staff members exited the building and walked past Resident #1. Resident #1 remained sitting in the wheelchair, slouched, with his chest to his knees, and arms dangling off the sides of the wheelchair, limp, with no movement until EMS arrived. He did not have a blanket or jacket to provide protection from the 29-degree Fahrenheit temperature.

According to www.accuweather.com, the low temperature was 29-degrees Fahrenheit on 1/7/23 in Burlington.

An interview with NA #1 on 01/09/23 at 3:36 PM revealed she was not assigned to work with

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" Providing emergency first aide for other accidents/incidents as needed-CPR, Rescue breathing, control bleeding, emergency oxygen, cleansing wounds/applying dressing, immobilizing fractures.
" Notification to physician/Next of Kin as soon as possible.
" Contacting EMS
" Assuring that licensed staff attend resident until EMS arrives, continue to monitor, assess and intervene as needed.
" Completion of documentation related to the incident.

Any nursing staff member that did not receive education on 1/12/23 will receive education by the beginning of the next shift by the DON or designee. The Staff Development Coordinator will be responsible for tracking staff that still require education. Any staff that has not received education will not be allowed to work until education is received. All new hire licensed staff will be educated by the Staff Development Coordinator on this policy. This education will be added to the orientation process. Staff Development was notified of this responsibility on 01/12/2023.

The DON or designee will verify the understanding of the education through oral discussion and feedback with all staff and notate this on a tracking tool. The SDC will also do this in orientation.

Nursing staff will complete a post- test based on the education provided. Staff

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Resident #1 on 01/07/23. She responded to the fire alarm sound and when she arrived at the nurses' station, she was instructed by the Night Shift Supervisor to bring Resident #1 to the outside front of the building. She indicated she saw Resident #1's injuries and described them as "his skin was peeled off his face and his hair was burned on the side." She indicated she was not given other instructions from the Night Shift Supervisor regarding providing aid to Resident #1. She further stated she could not remember if she provided Resident #1 with a covering to protect him from the 29-degree Fahrenheit temperature.

Nurse #1 was interviewed on 01/22/23 at 2:58 PM. She indicated she was assigned to work with Resident #1 on 01/07/23 and knew Resident #1 was dependent on oxygen. She indicated she was not on the floor when the incident occurred. She went to the front of the building because she was notified by other staff members Resident #1 had burned himself while smoking a cigarette. When she had arrived at the front of the building, EMS had already arrived. She indicated when she saw Resident #1, his head was down, and he was unresponsive. She did not assess Resident #1 because EMS had already arrived. Later in the interview, she stated the first time she checked Resident #1 for a pulse and respirations was when he was outside front of the building. She took his pulse and respirations manually and noted his breathing was shallow and his pulse was strong and within normal range. She stated she could not remember the pulse or respiration rates. She indicated she was not provided any instructions regarding providing aid to Resident #1 and did not indicate why she had not stayed with Resident #1.

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Development Coordinator is responsible for the post test and monitoring the post test results. The posttest is initiated on 01/13/2023.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
The Director of Nursing or Designee will monitor all newly hired staff to assure that they have received training for delivering emergent care and have successfully completed a posttest with acceptable passing scoring weekly x 4 weeks, bi-weekly x 1month then monthly x 1 month.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.
The administrator or designee will be responsible for reporting to the Quality Assurance Performance Improvement (QAPI) committee for recommendations and/or modifications until a pattern of compliance is achieved.
The Administrator is responsible for the entire plan of correction.

5. Date of completion: 2/06/2023

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NA #3 was interviewed on 01/10/23 at 10:25 AM. She indicated she was assigned to work with Resident #1 on 01/07/23, was familiar with his care needs, and knew he was oxygen dependent. She stated she had checked 10 to 15 minutes prior to the incident. She indicated she was outside of the building and was not on the floor when the incident occurred. The first time she saw Resident #1 after the incident was when he was outside on the stretcher with EMS.

Documentation of the Emergency Medical Services (EMS) report dated 01/07/23 revealed at 3:01 AM, EMS arrived on scene. Resident #1 was sitting in a wheelchair outside of the front door of the facility. Resident #1 was noted to be slouched/slumped over in the wheelchair. Staff was immediately asked if the resident was breathing and if the resident had a pulse. The nursing staff responded, "he's unconscious." EMS personnel, again, asked if the resident was breathing and if he had a pulse, "to which the nursing staff did not check the patient." EMS noted all nursing staff had no hands on the resident, the resident was not being assessed, nor was treatment administered by nursing staff prior to EMS arrival. EMS personnel quickly assessed the resident. The resident was found to not be breathing or have a pulse. EMS personnel asked the nursing staff about Resident #1's information and paperwork, and the staff responded with "we don't know anything about the patient, and there is a fire, so we can not [sic] get you that information." It was noted that nursing staff continued to enter and exit the front doors of the facility.

An interview was conducted with the responding

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Paramedic on 01/11/23 at 12:29 PM. The Paramedic stated when he arrived, he saw Resident #1 slumped over in a wheelchair outside in front of the facility. Resident #1 did not look like he was breathing. There were staff members around Resident #1; however, no staff member hand their hands on Resident #1. He stated staff members were either on their phones or walking around. He further indicated staff members could not report if Resident #1 was breathing or had a pulse. He also stated facility staff was not able to provide him Resident #1's name, date of birth, or medical conditions. When he assessed Resident #1 it was determined Resident #1 did not have a pulse or respirations. Resident #1 was assessed to the stretcher via 2-person manual lift and cardiopulmonary resuscitation (CPR) was started in the ambulance.

The Emergency Room hospital records indicated presented to the hospital with partial-thickness burns covering Resident #1's face and neck as well as clavicle and shoulder, approximately 10% of body surface area, and soot in the nostrils. The Emergency Room physician noted EMS reported Resident #1 was sitting in wheelchair with oxygen on via nasal cannula when he subsequently lit a cigarette that exploded in his face causing severe burns to the face, neck, shoulders, and clavicle. Resident #1 was noted to be unresponsive, without a pulse so CPR was initiated by EMS. CPR was performed for 30 minutes then his pulse and blood pressure returned. Resident #1 went into cardiac arrest again for several minutes and was intubated after his pulse and blood pressure returned for the second time. Due to his significant burns, the hospital initiated transfer to a local burn unit.

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F 684	Continued From page 32 A review of the Burn Attending Intensive Care Unit (ICU) hospital note dated 01/07/23 revealed Resident #1 was critically ill and sustained second- and third-degree flame burns to both sides of his face, both ears, left chest, left upper arm, left forearm, and back of left hand to 5.5% of his body. It was noted that he also went into cardiac arrest twice as well has having acute respiratory failure secondary to pulmonary edema (excess fluid in the lungs) and aspiration. An interview with the ICU Nurse #1 was conducted on 01/09/23 at 3:02 PM. She indicated Resident #1 was comatose, intubated, unable to speak, and had an anoxic brain injury (a brain injury caused by a complete lack of oxygen to the brain). Resident #1's code status was switched from Full Code to Do Not Resuscitate (DNR). The ICU Physician Assistant was interviewed on 01/10/23 at 12:32 PM. She indicated it was reported to her that Resident #1 was smoking at the facility and caught fire. He was found to be unresponsive and remained unresponsive since admission to the ICU burn unit. She stated his injuries were consistent with smoking while on oxygen. The ICU Attending Physician was interviewed on 01/11/23 at 9:39 AM via phone revealed at the time of the call, Resident #1 had an anoxic brain injury (brain injury which occurs due to lack of oxygen to the brain) and had a poor prognosis. He was intubated, in critical condition, and unresponsive. She indicated she did not expect a full recovery and a palliative care consult would be placed due to Resident #1's poor prognosis. An interview with ICU Nurse #2 was conducted	F 684		

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on 01/12/23 at 3:51 PM. She indicated Resident #1 remained in critical condition. Resident #1 was placed on comfort care with no aggressive treatment. He was not expected to recover, and death was imminent.

On 01/19/23 at 12:34 PM the ICU Receptionist was interviewed. She indicated Resident #1 died on 01/12/23 at 5:15 PM.

The Director of Nursing (DON) was interviewed on 01/09/22 at 1:57 PM. She stated she received a call from a staff member around 3:00 AM on 1/07/22 notifying her of Resident #1 sustaining injuries from lighting a cigarette while on oxygen. She indicated she did not see Resident #1 when she arrived at the facility as he had already been taken by ambulance; therefore, she was unable to assess Resident #1. She indicated she felt the staff responded appropriately to the emergency. The Administrator was notified of immediate jeopardy on January 11, 2023, at 7:35 PM.

The facility provided the following credible allegation for immediate jeopardy removal:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and

On 1/7/23, shortly before 3AM, Resident #1 was noted in doorway of his room as the Night Shift Supervisor was coming down the hall. She could see that smoke was coming from the room. She began to call his name and as she approached him, she could see his hair was singed. As she got closer, she called his name, and he did not answer as his head was down. She pushed his head up and back and noted his face was

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"melted off" referring to his burned face.

She immediately closed his door given the smoke detector was sounding and there was visible smoke, rescued him from danger to the nurses station, immediately pulled the fire alarm and called 911 for Emergency Medical Services (EMS) and Fire Rescue at 2:56am. While on the phone with 911, the Night Shift Supervisor assessed respirations and pulse and provided the information to dispatch as instructed. The 911 dispatcher asked her to get him to the front of the building to await pickup. The Night Shift Supervisor instructed the certified nurse aide (CNA) to take him to the front of the building to await EMS at the request of the 911 dispatch. In the meantime, the Night Shift Supervisor was asked to stay on the phone with the dispatcher. However, the nurse did not provide instruction to the certified nurse aide as to what to do for this resident; she didn't assess what the resident needed and failed to render emergency care to maintain Resident # 1's airway.

During the wait for EMS to arrive, the CNA states she and other staff watched him, took his pulse, and she and other staff continued to speak to him and touch him to reassure him knowing he was unresponsive. His body was severely slumped over in the chair at his torso. The CNA notes on interview that she and other staff handed him off to EMS upon their arrival at 3:02am. They dismissed themselves when EMS took over.

In review of this incident, the nurse and staff assigned to him after he left the unit failed to monitor and assess Resident #1 who had been through a traumatic event suffering multiple burns, did not assess him fully to know what

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nursing and medical needs he had, did not position the resident to promote breathing, did not cover the resident in 30 degree weather outside, and did not provide basic necessary services until EMS arrived. The nurse further sent him to the lobby with an unlicensed staff member who was unable to monitor him which was required per policy.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be completed.

Education began for nursing staff to include licensed nurses and nursing assistants on 1/12/23, by the DON or designee. Education included Nursing policy 1110-Emergency First Aide, and other information noted below.
Education included:
o Provision of emergency first aide as indicated by the situation to anyone in the center experiencing an accident or incident.
o A licensed nurse will assess injured persons, obtain vitals, monitor patient for changes. Obtain vital signs, pulse ox etc. as condition warrants.
o In the case of burn, protect airway, such as positioning, rescue breathing, CPR, emergency oxygen
o Providing emergency first aide for other accidents/incidents as needed-CPR, Rescue breathing, control bleeding, emergency oxygen, cleansing wounds/applying dressing, immobilizing fractures.
o Notification to physician/Next of Kin as soon as possible.
o Contacting EMS
o Assuring that licensed staff attend resident until EMS arrives, continue to monitor, assess

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and intervene as needed
o Completion of documentation related to the incident

Any nursing staff member that did not receive education on 1/12/23 will receive education by the beginning of the next shift by the DON or designee. The Staff Development Coordinator will be responsible for tracking staff that still require education. Any staff that has not received education will not be allowed to work until education is received. All new hire licensed staff will be educated by the Staff Development Coordinator on this policy. This education will be added to the orientation process. Staff Development was notified of this responsibility on 01/12/2023.

The DON or designee will verify the understanding of the education through oral discussion and feedback with all staff and notate this on a tracking tool. The SDC will also do this in orientation.

Nursing staff will complete a post- test based on the education provided. Staff Development Coordinator is responsible for the post test and monitoring the post test results. The post test is initiated on 01/13/2023.

Date of immediate jeopardy removal is January 14, 2023

Person responsible for implementation the plan is the Administrator

On 01/17/23, the facility's credible allegation for immediate jeopardy removal was validated by record review of in-services; multiple interviews

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F 684	Continued From page 37 with facility staff revealed they received education on the facility's Nursing Policy - 1110 Emergency First Aid and education on situation of accidents including the case of burns, assessment, notification, and effective communication; and interview with the Administrator affirming the education was provided by the Director of Nursing and Staff Development Coordinator. Immediate jeopardy was removed on 01/14/23.	F 684		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, fire department report review, Emergency Medical Services report review, and staff, facility's contracted transportation driver, facility's contracted transportation company's owner, fire department Captain, hospital staff, and Paramedic interviews, the contracted facility transportation company failed to notify the facility Resident #1 was observed to be smoking with an oxygen tank on his wheelchair, was in possession of cigarettes, a lighter, and repeatedly asked the driver to stop for cigarettes and coffee while en route to a physician's appointment. On 1/07/23 Resident #1 lit a cigarette in his room with oxygen in use and sustained second- and third-degree flame burns to both sides of his face, both ears, left chest, left	F 689	F689 1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and Resident #1 no longer resides in the center. Resident # 1 was taken to an appointment by a transportation company on January 6th. The transportation driver failed to communicate with the facility that Resident # 1 was observed by the transportation driver smoking with an oxygen tank present on his wheelchair and was observed in possession of smoking materials. The transportation driver failed to notify the facility that	2/6/23

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upper arm, left forearm, and back of left hand. EMS personnel immediately began cardiopulmonary resuscitation (CPR) once inside the ambulance. He went into cardiac arrest twice, was intubated, and became comatose. Resident #1 expired on 01/12/23. This is evidenced for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #1). In addition, the facility continued to assess a resident as safe to smoke without supervision after he was non-compliant with the facility's smoking policy for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #2).

Immediate jeopardy began on 01/06/23 when the contracted facility transportation company failed to notify the facility Resident #1 was smoking with an oxygen tank on the back of his wheelchair, was in possession of cigarettes, a lighter, and was repeatedly asking the driver to stop for coffee and cigarettes while en route to a physician's appointment. Immediate jeopardy was removed on 01/17/23 when the facility provided an acceptable credible allegation for immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of "D" (No actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure completion of education and monitoring systems put into place are effective.

Example #2 for Resident #2 was cited at a scope and severity of "D".

The findings included:
1. The hospital discharge summary dated 12/29/22 revealed Resident #1 is to place one 21 milligram (mg) Nicotine patch on the skin daily (reason unspecified) as well as to utilize oxygen

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Resident #1 had requested numerous times during the transportation to stop and purchase smoking materials. As a result, on 1/7/23, shortly before 3AM, resident #1 was noted in doorway of his room as the Night Shift Supervisor was coming down the hall. She could see that smoke was coming from the room. She began to call his name and as she approached him, she could see his hair was singed. As she got closer, she called his name, and he did not answer as his head was down. She pushed his head up and back and noted his face was melted off referring to his burned face.
All residents that are transported to appointments by a transport company and residents that are not compliant with smoking policy have the potential to be affected by this deficient practice.
2. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be completed.
Education began on 1/7/23, for all staff in all departments by Staff Development Coordinator Education included:
The smoking policy, including but not limited to:
o Those patients currently assessed as deemed independent vs supervised for safety for smoking and supervised smoking times as indicated on the updated smoking list which was revised on 1/7/23 and is available at all nursing stations. The Director of Nursing was responsible for updating the list of supervised smokers on 1/7/23 and will

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at 4 liters continuously was also ordered (reason unspecified).

Resident #1 was admitted to the facility on 12/29/22 with multiple diagnoses which included Chronic Obstructive Pulmonary Disease, respiratory failure, peripheral vascular disease, heart failure, and tobacco use.

Resident #1 was admitted to and remained in a private room.

A physician's order dated 12/29/22 revealed Resident #1 to utilize oxygen at 4 liters per minute via nasal cannula every day and night shift.

A physician's order dated 12/29/22 staff is to pipe oxygen into Resident #1's BiPAP machine (a device that helps with breathing which pushes air into the lungs) every night shift and as needed for low oxygen saturation levels and shortness of breath.

A physician's order dated 12/29/22 stated apply one 24-hour 21 milligrams Nicotine patch transdermal (on the skin) one time a day for nicotine cessation for 6 weeks and remove per schedule.

A physician's order dated 12/29/22 stated apply one 24- hour 14 milligrams Nicotine patch transdermal (on the skin) one time a day for smoking cessation for 2 weeks and remove per schedule.

A physician's order dated 12/29/22 stated apply one 24-hour 7 milligrams Nicotine patch transdermal (on the skin) one time a day for smoking cessation for 2 weeks and remove per

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update smoking list as necessary.

o Monitoring patient behavior and activity in room related to having combustible materials on self and reporting it to the charge nurse and/or supervisor for follow-up.

o Monitoring changes in the condition of patients that previously were non-smoking in the center, but who may express a desire to smoke, and reporting this to the charge nurse and/or supervisor for follow-up.

o Immediately notifying administrator and/or Director of Nursing at the time of occurrence for any resident caught smoking out of the designated times and area. Consequences of smoking with oxygen on can result in serious injury.

o Nurse management (director of nursing, assistant director of nursing, unit managers and/or staff development coordinator) will remove any employee that did not receive the education from the schedule until education is completed. The staff development coordinator is responsible for tracking that staff have received the required training prior to working their next shift. All future employees will be educated by staff development coordinator on the above in-services during new hire orientation. Current staff have received this education. The Staff Development Coordinator is tracking this information to ensure no staff works that have not received the education.

o Education began on 1/7/23 for all nurses, discharge planners and IDT on completion of the smoking assessment

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schedule.

The admission nursing assessment dated 12/29/22 revealed Resident #1 was cognitively intact and required supervision with chair/bed-to-transfers.

The Smoking Safety Screen dated 12/29/22 completed by the Unit Manager revealed Resident #1 did not smoke.
A nursing note written by the Unit Manager on 12/29/22 at 4:10 PM stated "Resident stated that he has not had a cigarette in 2 months and did not have the urge to smoke. Writer made resident aware that he will be on nicotine patches."

Resident #1's care plan dated 01/03/23 indicated Resident #1 is at risk for respiratory complications due to Chronic Obstructive Pulmonary Disease, respiratory failure, supplementary oxygen requirement and Bilevel Positive Airway Pressure machine (a machine used to help push air into lungs and opens airway). The goal was for Resident #1 to be free from respiratory complications through the review period. Interventions included: administer medications as ordered; administer nebulizer treatments as ordered; administer oxygen as ordered; BiPAP as ordered; observe for signs and symptoms of respiratory complications; and vitals as needed.

The Unit Manager was interviewed on 01/09/23 at 12:30 PM. She indicated she completed Resident #1's admission on 12/29/22 and was familiar with him. Resident #1 was admitted directly from the hospital. Resident #1 was cognitively intact during her assessment. She completed the Smoking Safety Screen and indicated Resident #1 does

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and discussion of the smoking acknowledgement with all new admissions by the DON, SDC or designee, including discussions with patients who state they are not a current smoker but have a history of smoking, and education to patients desiring to smoke but who wear oxygen. This education will be done by the SDC, DON or designee. All disciplines were educated on their responsibility on 01/09/2023. All new admissions will be discussed during morning clinical meeting with the disciplines and updates on progress of assigned task.
Anyone working after 1/7/23 who has not received the education will not be allowed to work. This education will also be done in orientation beginning of 1/7/23, for all new hire nurses and new hire members of the IDT. Staff Development Coordinator will track and ensure education is provided. Staff Development Coordinator was notified of this responsibility on 1/07/2023.
o All smoking assessments and care plans for current smokers were reviewed and updated by the Interdisciplinary Team (IDT) to assure appropriateness of supervised vs. unsupervised smoking status. This was completed by the Director of Nursing or designee on 1/7/23.
o All new admissions for the last 30 days will be reviewed for evidence of a smoking assessment and their completion, as well as the care plan for anyone desiring to smoke by 1/8/23 by the DON or designee.
o On 1/8/23 all residents POC Kardex

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not smoke. She stated Resident #1 indicated he did not want to smoke and had no desire to smoke while at the facility. She reviewed the facility's smoking policy and Resident #1 voiced understanding. While completing his admission, she did not notice any smoking materials in Resident #1's possessions. She did not recall Resident #1 ever having friends or family visit him while at the facility. She indicated she was aware of the facility's smoking policy that all smoking materials are to be kept at the nurses' station until ready to be used and smoking materials should not be kept in resident's rooms.

An interview with the facility's contracted transportation driver on 01/10/22 at 4:43 PM revealed he picked Resident #1 up in the morning on 01/06/22 to transport him to a physician's appointment. Resident #1 frequently asked for the driver to stop at a store to purchase coffee and cigarettes while he was transporting Resident #1 to his physician's appointment. He told Resident #1 he could not stop and proceeded to drive to the physician's office. He stated when picking up Resident #1 after his physician's appointment, Resident #1 was outside of the physician's office, on an elevator lift, and smoking a cigarette with an oxygen tank on the back of his wheelchair. He told Resident #1 he could not smoke while on oxygen or while in the transportation van. He requested Resident #1 to put the cigarette out. Resident #1 agreed to stop smoking and threw the cigarette off the side of the elevator lift (The lift is a platform that is used to raise clients in wheelchairs to the level of the parking lot). On the way back to the facility, Resident #1 only asked to stop for a cup of coffee. He reminded Resident #1 that he could not make any additional stops. He stated he

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were updated to reflect smoking designation as supervised smoker, unsupervised smoker, or history of smoking. The resident Point of Care Kardex is seen on the Certified Nursing Assistance kiosk where daily resident review and documentation is done by the certified nursing assistants each shift.
Education began on 1/7/23, for all staff in all departments by Staff Development Coordinator Education included:
"   All current patients that smoke received re-education of the smoking policy, smoking acknowledgements for all current smokers and all new admits were re-reviewed and completed on 1/8/23 by the discharge planning director or designee. The smoking policy states smoking materials will not be kept in the patient room.
"   For all current smokers and all new admissions, the discharge planner or designee will educate responsible parties/emergency contacts on proper providing and delivery of smoking materials to the charge nurse for safe keeping. The discharge planner performs this task by going over the smoking policy and having the resident or resident representative sign the smoking acknowledgement.   Any new admission that arrives with smoking materials will have their smoking materials taken and properly stored in secure area by the discharge planners. Discharge planners contacted all emergency contacts/responsible parties and provided verbal education on smoking policy specifically delivery of smoking materials

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reported his observations to the owner of the facility's contracted transportation company.

During a follow up interview on 01/10/23 at 1:21 PM the facility's contracted transportation driver reiterated Resident #1 was on the outside elevator lift when he arrived. Resident #1 had a lit cigarette in his hand. The cigarette was about half-way gone. He told Resident #1 that he could not smoke in the van or while on oxygen. Resident #1 agreed and put the cigarette out by throwing it over the side of the elevator lift.

An additional interview with facility's contracted transportation driver was conducted on 01/11/23 at 9:24 AM. He, again, stated when he arrived to pick Resident #1 from his physician's appointment Resident #1 was smoking a lit cigarette with an oxygen tank on the back of his wheelchair. Resident #1 had a package of cigarettes and a lighter in his hands. He told Resident #1 that he could not smoke with oxygen on or smoke in the transportation van. He stated Resident #1 voiced understanding and put the cigarette out.

On 01/10/23 at 11:34 AM with the owner of the facility's contracted transportation company revealed the driver did not notify him of his observations of Resident #1 smoking or asking for cigarettes until after the nursing home facility started their investigation on 01/07/23. He stated if the driver had notified him of the observations, he would have notified the facility.

An interview with the Scheduler at the physician's office was conducted on 01/10/23 at 2:15 PM. She stated Resident #1 sat in the lobby until

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and storage. This will be completed on 01/16/2023.

" To ensure that smoking materials are returned for all smokers, residents are assisted from smoking patio by staff and smoking materials are placed in the designated locked and secured location. A smoking attendant is assigned to monitor the smoking area 8a-8p and will be noted on the daily nursing staffing sheets to communicate what staff member is assigned. The facility scheduler will be responsible for assuring that the assignment sheet notates what staff is assigned each shift as smoking attendant. The smoking attendant will collect smoking material when they return inside from the smoking area. The smoking attendant will distribute the smoking material when the resident goes to smoke. Between the hours of 8p-8a, if a resident, who is deemed a safe smoker would like to smoke a smoking attendant will be assigned individually as needed to distribute the resident their smoking materials and at the end of the smoking session retrieve smoking materials to be returned to proper storage location. All current safe/unsupervised smokers will be educated on this process by the Director of Nursing or designee beginning on 1/14/23 and this education will be tracked by the Staff Development Coordinator. The smoking attendant will supervise all unsupervised smokers and distribute and collect their smoking materials. Education began to all staff on the new smoking process by the Director of Nursing or designee on 01/14/2023 on the

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transportation came. She assisted Resident #1 on the outside elevator then the transportation driver helped him onto the transportation van. She stated she could not recall Resident #1 having a cigarette or lighter visible when she assisted Resident #1 outside.

The nursing note written by the Night Shift Supervisor in the electronic medical record of Resident #1 dated 01/07/23 at 3:15 AM stated, "Resident found unresponsive and breathing in front of room door in W/C [wheelchair] with burns to face and hair. Transferred to nurses' station and called 911. Instructed by 911 to bring resident to front of building by EMS and transferred care to EMS."

An interview was conducted with the Night Shift Supervisor on 01/09/23 at 10:30 AM. Night Shift Supervisor stated at about 3:00 AM on 01/07/23 she was sitting at the nurses' station when she heard "an annoying beeping sound," which she later discovered was from the room's smoke detector. She got up to investigate the noise. As she walked down the hall, she saw and smelled gray smoke coming from Resident #1's room. She yelled "I know you're not smoking!" to Resident #1. When she reached Resident #1, she saw him in the doorway of his room, sitting upright, with his head down. She lifted his head and noticed Resident #1's face and hair severely burned, he was breathing, and unresponsive. She described his facial burns as "it was like his face melted off." She immediately brought Resident #1 into the hallway via his wheelchair and closed the door. She pushed him to the nurses' station, pulled the fire alarm, and called 911. She stated she was instructed to escort Resident #1 to the front of the building and to stay on the phone. She

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responsibilities of the smoking attendant, location of assignment sheet, and appropriate storage of smoking materials. Any staff that have not received this education will not be allowed to work until they have received the required education.

" On 1/7/23 all smoking residents rooms and persons were searched with consent by Director of Nursing and Unit manager and all smoking materials were confiscated and placed behind locked doors. Unit manager provided education to smokers on risks of having smoking materials in room and on person. Unsupervised smokers verbalized understanding of this policy.

The Staff Development Coordinator will provide the education in writing to the third-party vendor on 1/13/23 who will then communicate the written education to the two transportation companies utilized by the facility and all drivers assigned to drive for the facility. Education will be provided by our third-party entity who provides administrative oversite for all transportation vendors for Alamance Nursing and Rehabilitation.

Any driver not educated will not be allowed to transport residents from the center until education has been received. The third-party entity will communicate with the center that the transportation

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indicated she did not know Resident #1 smoked. She stated she never saw smoking materials in his room and Resident #1 never asked about smoking.

Additional interview with the Night Shift Supervisor was conducted on 1/10/23 at 10:44 AM. Resident #1 was not on fire and there was not a fire actively burning. She stated Resident #1 was wearing clothes when the incident had started, and a gray burned shirt was found on the floor. When she approached Resident #1, she could smell burned flesh and hair. His long hair and long beard were burned unevenly including all the way up to one of his ears. She could not remember which ear was burned.

An interview with NA #1 on 01/09/23 at 3:36 PM revealed she was not assigned to work with Resident #1 on 01/07/23. She further indicated she was not familiar with Resident #1 and had never worked with him. She was responding to the fire alarm when she was instructed by the Night Shift Supervisor to take Resident #1 to the front.

Documentation of the Emergency Medical Services (EMS) report dated 01/07/23 revealed at 3:01 AM, EMS arrived on scene. Resident #1 was sitting in a wheelchair outside of the front door of the facility. Resident #1 was noted to be slouched/slumped over in the wheelchair. Staff was immediately asked if the resident was breathing and if the resident had a pulse. The nursing staff responded, "he's unconscious." EMS personnel, again, asked if the resident was breathing and if he had a pulse, "to which the nursing staff did not check the patient." It was noted that all nursing staff had no hands on the

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companies have been educated. This education will be tracked by the Staff Development Coordinator. Drivers that did not complete the education on 1/13/23, will not be allowed to transport for the center until education is received. The Staff Development Coordinator or designee will educate all service ambassadors and the in-house transportation coordinator on the written education received by the transportation companies and responsibilities for verifying and providing education on 1/13/23. The service ambassadors and in-house transportation scheduler, located at the front desk will verify with any driver that reports to pick up a resident has received the required education by asking the driver when they enter the facility. Transportation drivers are required come into the facility to check out the resident for the transport. When a new transportation driver is hired by the company verification of education will be forwarded from the third-party entity to the facility for tracking of required education.

The service ambassadors and facility appointment scheduler will be educated on 01/13/2023 on the same items as the transportation company drivers by the Staff Development Coordinator

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
Administrator or designee will monitor by

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resident, the resident was not being assessed, nor was treatment administered by nursing staff prior to EMS arrival. EMS personnel quickly assessed the resident. The resident was found to not be breathing or have a pulse. EMS personnel asked the nursing staff about Resident #1's information and paperwork, and the staff responded with "we don't know anything about the patient, and there is a fire, so we can not [sic] get you that information." It was noted that nursing staff continued to enter and exit the front doors of the facility.

An interview was conducted with the responding paramedic on 01/11/23 at 12:29 PM. The Paramedic stated when he arrived, he saw Resident #1 slumped over in a wheelchair outside front of the facility building. Resident #1 did not look like he was breathing. There were staff members around Resident #1; however, no staff member hand their hands on Resident #1. He stated staff members were either on their phones or walking around. He further indicated staff members could not report if Resident #1 was breathing or had a pulse. He also stated facility staff was not able to provide him Resident #1's name, date of birth, or medical conditions. When he assessed Resident #1 it was determined Resident #1 did not have a pulse or respirations. Resident #1 was assessed to the stretcher via 2-person manual lift and cardiopulmonary resuscitation (CPR) was started in the ambulance. He further indicated Resident #1's eyes were swollen and not opened as well has had third degree burns on face and charring on his nose.

Documentation of the Fire Department report dated 01/07/23 revealed at 3:03 AM the fire

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reviewing facility in-service sheet for new driver signature which will include review of any newly hired transportation drivers to assure that they have received the required education at the facility and completion of the questionnaire

Education to the transportation drivers; service ambassadors, facility appointment scheduler will include.
Safety concerns would include but not be limited to unbuckling, attempts to stand, attempts to smoke, known smoking or vaping.
" Type of concerns to report-behaviors, unusual requests for stops, noncompliance with safety directions during transport. This will be part of the ongoing orientation process for the transportation vendors to use in their orientation process.
" Returning the resident to facility and drop off procedure to include reporting concerns to Service Ambassador. The service ambassador is located at the front desk at the front door. The service ambassador is located at the front desk from the hours 8am- 8pm. If the transportation driver returns when the service ambassador is not available, the charge nurse for the patient will be notified by the transportation driver. Education provided to the Service Ambassadors and Charge Nurses by the Staff Development Coordinator is listed below
o Any concerns noted by Service Ambassador will be immediately given to the charge nurse, unit manager or supervisor for follow up. The service

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department arrived on scene. The location of the incident was Resident #1's room. Upon arrival to the room, they found the door was shut and inside of the room was light to moderate smoke and found no fire. After gathering information from the facility staff and investigating, it was determined the incident occurred due to Resident #1 was attempting to smoke a cigarette while on oxygen. The factor which contributed to ignition was "misuse of material."

An interview was conducted with the responding Fire Department Captain on 01/11/23 at 10:42 AM. He stated EMS was on scene upon his arrival and was attending to Resident #1. When he investigated the fire, the room was filled with residual smoke as well as powder from a fire extinguisher. He noticed a gray shirt on the floor with burns. He further indicated there was melted oxygen tubing located on the floor as well. He stated it was determined Resident #1 had a history of smoking and was attempting to smoke while on oxygen.

The Emergency Room hospital records dated 01/07/23 indicated Resident #1 presented to the hospital with partial-thickness burns covering Resident #1's face and neck as well as clavicle and shoulder, approximately 10% of body surface area, and soot in the nostrils. The Emergency Room physician noted EMS reported Resident #1 was sitting in wheelchair with oxygen on via nasal cannula when he subsequently lit a cigarette that exploded in his face causing severe burns to the face, neck, shoulders, and clavicle. Resident #1 was noted to be unresponsive, without a pulse so CPR was initiated by EMS. CPR was performed for 30 minutes then his pulse and blood pressure returned. Resident #1 went into cardiac arrest

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ambassador is the front desk attendant. Education will be provided to current service ambassadors by Staff Development Coordinator on 01/13/2023. Any service ambassador will not be able to work until they have received education by the staff development coordinator.

o Charge Nurses will be educated by Staff Development Coordinator on what the appropriate steps to take when receiving report from transportation driver or service ambassador. Education will include implementation of appropriate interventions, updating care plans and notifying medical provider as needed.
" Transportation drivers, service ambassadors and charge nurses that are not scheduled to work 01/13/2023 will receive education before their next scheduled shift. Staff Development Coordinator is responsible for the education and ongoing monitoring of the education.
This will be conducted weekly x4 weeks, bi-weekly x 4 weeks then monthly x1 month.
4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;
The administrator or designee will be responsible for reporting of the findings to the Quality Assurance Performance Improvement (QAPI) committee for recommendations and/or modifications until a pattern of compliance is achieved.
Ther Administrator is responsible for the plan of correction.

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F 689	Continued From page 47 again for several minutes and was intubated after his pulse and blood pressure returned for the second time. Due to his significant burns, the hospital initiated a transfer to a local burn unit. A review of the Burn Attending Intensive Care Unit (ICU) hospital note dated 01/07/23 revealed Resident #1 was critically ill and sustained second- and third-degree flame burns to both sides of his face, both ears, left chest, left upper arm, left forearm, and back of left hand to 5.5% of his body. It was noted that he also went into cardiac arrest twice as well has having acute respiratory failure secondary to pulmonary edema (excess fluid in the lungs) and aspiration. An interview with ICU Nurse #1 was conducted on 01/09/23 at 3:02 PM. She indicated Resident #1 was comatose, intubated, unable to speak, and had an anoxic brain injury (a brain injury caused by a complete lack of oxygen to the brain). Resident #1's code status was switched from Full Code to Do Not Resuscitate (DNR). The ICU Physician Assistant was interviewed on 01/10/23 at 12:32 PM. She indicated it was reported to her that Resident #1 was smoking at the facility and caught fire. He was found to be unresponsive and remained unresponsive since admission to the ICU burn unit. She stated his injuries were consistent with smoking while on oxygen. The ICU Attending Physician was interviewed on 01/11/23 at 9:39 AM via phone revealed at the time of the call, Resident #1 had an anoxic brain injury (brain injury which occurs due to lack of oxygen to the brain) and had a poor prognosis. He was intubated, in critical condition, and	F 689	5. Date of completion: 2/6/2023	

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unresponsive. She indicated she did not expect a full recovery and a palliative care consult would be placed due to Resident #1's poor prognosis.

An interview with ICU Nurse #2 was conducted on 01/12/23 at 3:51 PM. She indicated Resident #1 remained in critical condition. Resident #1 was placed on comfort care with no aggressive treatment. He was not expected to recover, and death was imminent.

On 01/19/23 at 12:34 PM the ICU Receptionist was interviewed. She indicated Resident #1 died on 01/12/23 at 5:15 PM.

An observation of Resident #1's room on 01/09/23 at 9:30 AM revealed 5 permanent dark brown burn marks on the linoleum tile floor on the left side of the bed, which was located near the window. One burn mark was approximately 5" (inches) x 2"; one was approximately 4" x 3", one was approximately 4" x 2", and two were approximately 1" x 1". The areas felt rough to the touch.

NA #2 was interviewed on 01/10/23 at 10:25 AM. She indicated she was assigned to work with Resident #1 on 01/07/23, was familiar with his care needs, and knew he was oxygen dependent. She stated she did not know Resident #1 smoked. He never asked for cigarettes, lighters, matches, or to go outside to smoke. She stated she had checked 10 to 15 minutes prior to the incident and did not notice anything abnormal.

An interview with NA #3 on 01/09/23 at 11:40 AM revealed she had only worked with Resident #1 one time. While working with Resident #1, she never saw cigarettes or lighters in his room or in

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his possession. She further stated Resident #1 never asked her about smoking.

An interview with Housekeeper #1 on 01/09/23 at 1:11 PM revealed she frequently cleaned Resident #1's room. She stated she did not know Resident #1 smoked. She never saw smoking materials in his room, and he never asked her about smoking while she cleaned his room.

The Social Worker was interviewed on 01/09/23 at 2:15 PM. He stated he was familiar with Resident #1. He introduced himself to Resident #1 a week before the incident. He asked Resident #1 if he was a smoker, and Resident #1 denied being a smoker. He stated Resident #1 knew about the smoking policy. He further provided education to Resident #1 regarding oxygen safety which included safe mobility in the room while wearing oxygen and smoking while on oxygen. This education is provided to all residents who utilize oxygen.

The Director of Nursing (DON) was interviewed on 01/09/22 at 1:57 PM. She stated she received a call from a staff member around 3:00 AM on 1/07/22 notifying her of Resident #1 sustaining injuries from lighting a cigarette while on oxygen. She indicated she did not see Resident #1 when she arrived at the facility as he had already been taken by ambulance; therefore, she was unable to assess Resident #1. She indicated she felt the staff responded appropriately to the emergency. When she investigated the room, she noticed a gray burned shirt on the floor as well as 5 burned marks on linoleum tile flooring. Additionally, she saw approximately 6 to 10 feet of melted oxygen tubing. There was a lighter located under the window's Packaged Terminal Air Conditioner

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(PTAC) unit and a package of cigarettes hidden in an animal cracker package with one cigarette missing. She threw the gray shirt away as well as the oxygen tubing. She did not indicate why she had thrown these items away. She stated the Smoking Safety Screens were completed at admission, quarterly, and whenever a residents changed their mind about smoking. She indicated the charge nurse or the unit manager completes the Smoking Safety Screen. The Unit Manager completed Resident #1's Smoking Safety Screen. She did not know where Resident #1 obtained smoking materials.

The Administrator was notified of immediate jeopardy on January 12, 2023, at 5:43 PM.

The facility provided the following credible allegation for immediate jeopardy removal:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and
Resident # 1 was taken to an appointment by a transportation company on January 6th. The transportation driver failed to communicate with the facility that Resident # 1 was observed by the transportation driver smoking with an oxygen tank present on his wheelchair and was observed in possession of smoking materials. The transportation driver failed to notify the facility that Resident #1 had requested numerous times during the transportation to stop and purchase smoking materials. As a result, on 1/7/23, shortly before 3AM, resident #1 was noted in doorway of his room as the Night Shift Supervisor was coming down the hall. She could see that smoke was coming from the room. She began to call his name and as she approached him, she could see

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F 689	Continued From page 51 his hair was singed. As she got closer, she called his name, and he did not answer as his head was down. She pushed his head up and back and noted his face was "melted off" referring to his burned face. All residents that are transported to appointments by a transport company and residents that are not compliant with smoking policy have the potential to be affected by this deficient practice. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be completed. Education began on 1/7/23, for all staff in all departments by Staff Development Coordinator Education included: The smoking policy, including but not limited to: o Those patients currently assessed as deemed independent vs supervised for safety for smoking and supervised smoking times as indicated on the updated smoking list which was revised on 1/7/23 and is available at all nursing stations. The Director of Nursing was responsible for updating the list of supervised smokers on 1/7/23 and will update smoking list as necessary. o Monitoring patient behavior and activity in room related to having combustible materials on self and reporting it to the charge nurse and/or supervisor for follow-up. o Monitoring changes in the condition of patients that previously were non-smoking in the center, but who may express a desire to smoke, and reporting this to the charge nurse and/or supervisor for follow-up. o Immediately notifying administrator and/or Director of Nursing at the time of occurrence for	F 689		

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any resident caught smoking out of the designated times and area. Consequences of smoking with oxygen on can result in serious injury.
o Nurse management (director of nursing, assistant director of nursing, unit managers and/or staff development coordinator) will remove any employee that did not receive the education from the schedule until education is completed. The staff development coordinator is responsible for tracking that staff have received the required training prior to working their next shift. All future employees will be educated by staff development coordinator on the above in-services during new hire orientation. Current staff have received this education. The Staff Development Coordinator is tracking this information to ensure no staff works that have not received the education.

o Education began on 1/7/23 for all nurses, discharge planners and IDT on completion of the smoking assessment and discussion of the smoking acknowledgement with all new admissions by the DON, SDC or designee, including discussions with patients who state they are not a current smoker but have a history of smoking, and education to patients desiring to smoke but who wear oxygen. This education will be done by the SDC, DON or designee. All disciplines were educated on their responsibility on 01/09/2023. All new admissions will be discussed during morning clinical meeting with the disciplines and updates on progress of assigned task.

Anyone working after 1/7/23 who has not received the education will not be allowed to work. This education will also be done in orientation beginning of 1/7/23, for all new hire

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F 689	Continued From page 53 nurses and new hire members of the IDT. Staff Development Coordinator will track and ensure education is provided. Staff Development Coordinator was notified of this responsibility on 1/07/2023. o All smoking assessments and care plans for current smokers were reviewed and updated by the Interdisciplinary Team (IDT) to assure appropriateness of supervised vs. unsupervised smoking status. This was completed by the Director of Nursing or designee on 1/7/23. o All new admissions for the last 30 days will be reviewed for evidence of a smoking assessment and their completion, as well as the care plan for anyone desiring to smoke by 1/8/23 by the DON or designee. o On 1/8/23 all residents' POC Kardex were updated to reflect smoking designation as supervised smoker, unsupervised smoker, or history of smoking. The resident Point of Care Kardex is seen on the Certified Nursing Assistance kiosk where daily resident review and documentation is done by the certified nursing assistants each shift. Education began on 1/7/23, for all staff in all departments by Staff Development Coordinator Education included: All current patients that smoke received re-education of the smoking policy, smoking acknowledgements for all current smokers and all new admits were re-reviewed and completed on 1/8/23 by the discharge planning director or designee. The smoking policy states smoking materials will not be kept in the patient room. For all current smokers and all new admissions, the discharge planner or designee will educate	F 689		

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responsible parties/emergency contacts on proper providing and delivery of smoking materials to the charge nurse for safe keeping. The discharge planner performs this task by going over the smoking policy and having the resident or resident representative sign the smoking acknowledgement. Any new admission that arrives with smoking materials will have their smoking materials taken and properly stored in secure area by the discharge planners. Discharge planners contacted all emergency contacts/responsible parties and provided verbal education on smoking policy specifically delivery of smoking materials and storage. This will be completed on 01/16/2023.

To ensure that smoking materials are returned for all smokers, residents are assisted from smoking patio by staff and smoking materials are placed in the designated locked and secured location. A smoking attendant is assigned to monitor the smoking area 8a-8p and will be noted on the daily nursing staffing sheets to communicate what staff member is assigned. The facility scheduler will be responsible for assuring that the assignment sheet notates what staff is assigned each shift as smoking attendant. The smoking attendant will collect smoking material when they return inside from the smoking area. The smoking attendant will distribute the smoking material when the resident goes to smoke. Between the hours of 8p-8a, if a resident, who is deemed a safe smoker would like to smoke a smoking attendant will be assigned individually as needed to distribute the resident their smoking materials and at the end of the smoking session retrieve smoking materials to be returned to proper storage location. All current safe/unsupervised smokers will be educated on this process by the

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F 689	Continued From page 55 Director of Nursing or designee beginning on 1/14/23 and this education will be tracked by the Staff Development Coordinator. The smoking attendant will supervise all unsupervised smokers and distribute and collect their smoking materials. Education began to all staff on the new smoking process by the Director of Nursing or designee on 01/14/2023 on the responsibilities of the smoking attendant, location of assignment sheet, and appropriate storage of smoking materials. Any staff that have not received this education will not be allowed to work until they have received the required education. On 1/7/23 all smoking residents' rooms and persons were searched with consent by Director of Nursing and Unit manager and all smoking materials were confiscated and placed behind locked doors. Unit manager provided education to smokers on risks of having smoking materials in room and on person. Unsupervised smokers verbalized understanding of this policy. The Staff Development Coordinator will provide the education in writing to the third-party vendor on 1/13/23 who will then communicate the written education to the two transportation companies utilized by the facility and all drivers assigned to drive for the facility. Education will be provided by our third-party entity who provides administrative oversite for all transportation vendors for Alamance Nursing and Rehabilitation. Any driver not educated will not be allowed to transport residents from the center until education has been received. The third-party entity will communicate with the center that the transportation companies have been educated. This education will be tracked by the Staff	F 689		

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Development Coordinator. Drivers that did not complete the education on 1/13/23, will not be allowed to transport for the center until education is received. The Staff Development Coordinator or designee will educate all service ambassadors and the in-house transportation coordinator on the written education received by the transportation companies and responsibilities for verifying and providing education on 1/13/23. The service ambassadors and in-house transportation scheduler, located at the front desk will verify with any driver that reports to pick up a resident has received the required education by asking the driver when they enter the facility. Transportation drivers are required come into the facility to check out the resident for the transport. When a new transportation driver is hired by the company verification of education will be forwarded from the third-party entity to the facility for tracking of required education.

The service ambassadors and facility appointment scheduler will be educated on 01/13/2023 on the same items as the transportation company drivers by the Staff Development Coordinator.

Education to the transportation drivers; service ambassadors, facility appointment scheduler will include.
Safety concerns would include but not be limited to unbuckling, attempts to stand, attempts to smoke, known smoking or vaping.
o Type of concerns to report-behaviors, unusual requests for stops, noncompliance with safety directions during transport. This will be part of the ongoing orientation process for the

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transportation vendors to use in their orientation process.
o Returning the resident to facility and drop off procedure to include reporting concerns to Service Ambassador. The service ambassador is located at the front desk at the front door. The service ambassador is located at the front desk from the hours 8am- 8pm. If the transportation driver returns when the service ambassador is not available, the charge nurse for the patient will be notified by the transportation driver.
Education provided to the Service Ambassadors and Charge Nurses by the Staff Development Coordinator is listed below
o Any concerns noted by Service Ambassador will be immediately given to the charge nurse, unit manager or supervisor for follow up. The service ambassador is the front desk attendant.
Education will be provided to current service ambassadors by Staff Development Coordinator on 01/13/2023. Any service ambassador will not be able to work until they have received education by the staff development coordinator.
o Charge Nurses will be educated by Staff Development Coordinator on what the appropriate steps to take when receiving report from transportation driver or service ambassador. Education will include implementation of appropriate interventions, updating care plans and notifying medical provider as needed.

Transportation drivers, service ambassadors and charge nurses that are not scheduled to work 01/13/2023 will receive education before their next scheduled shift. Staff Development Coordinator is responsible for the education and ongoing monitoring of the education.

Date of IJ removal: 1/17/23

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Person responsible for implementation of the plan is Administrator.

On 01/17/23, the facility's credible allegation for immediate jeopardy removal was validated by record review of the Activity Reporting Procedures document related to residents' transportation which included smoking, vaping, and signed by five contracted transportation drivers; staff interviews of educated regarding smoking safety with supervised and unsupervised smokers, location of combustible materials, location of smoking designation area, reporting smoking concerns, and consequences of smoking with oxygen; interview with the Administrator which indicated the Director of Nursing provided education to staff, smoking residents received re-education on the smoking policies and the Staff Development Coordinator educated third-party transportation company drivers; and an interview with the facility's contracted transportation driver indicated he received re-education related to activity during transportation. The immediate jeopardy was removed on 01/17/23.

2. The facility's Smoking Policy dated 10/24/22 indicated "the Center promotes a smoke-free environment to protect the health, safety, and well-being of all our patients; therefore, the Center maintains a policy of no smoking within the building by anyone at any time." Procedures included "the Administrator will designate areas outside of the building for any smoking activities;" "a patient may smoke in designated smoking areas: if the patient has been assessed by the interdisciplinary team and it has been determined

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through the Smoking Safety Screen that it is safe for the patient to smoke;" and "all instruments that cause a spark or a flame (igniting products) will be kept in a locked location, as well as any electronic delivery systems."

Resident #2 was admitted to the facility on 08/03/22 with diagnoses that included spinal stenosis, muscle weakness, difficulty in walking, high blood pressure, left sided muscle weakness due to stroke.

The quarterly Minimum Date Set (MDS) dated 12/01/22 revealed Resident #2's cognition was mildly impaired. He required extensive assistance with transfers, dressing, toilet use, and personal hygiene.

Resident #2's most recent care plan dated 12/12/22 revealed a focus area indicating the resident prefers to smoke cigarettes. The goal stated the resident will smoke safely through the review period. Interventions included Resident #2 to be educated on the facility smoking policy; may smoke independently; signed all consent to smoke; and complete smoking assessment as needed.

The Smoke Safety Screen dated 08/11/22 indicated Resident #2 smoked and did not have any cognitive loss, had no visual or dexterity problems. He understood smoking may only take place at designated times; smoking accessories must be returned to and kept under control of the facility staff when not in use. He was labeled as safe to smoke without supervision.

A behavior nursing note dated 12/04/22 at 10:36PM Resident #2 was smoking in room. The

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cigarettes and lighter were locked in the medication cart. Resident #2 agreed to the intervention and was re-educated on the smoking policy. This note was documented by Nurse #3.

Resident #2 nor his roommate had an order for oxygen. Resident #2 was not within 15 feet of an oxygen source at the time of the incident.

Nurse #3 was interviewed on 01/11/23 at 4:02 PM. She indicated she was not assigned to work with Resident #2 but was walking by the room when she smelled cigarette smoke. When she entered the room, she saw Resident #2 drop the cigarette in a cup. She took the cigarette and lighter away from Resident #2 and re-educated him on the smoking policy.

The Smoke Safety Screen dated 12/05/22 indicated Resident #2 smoked and did not have any cognitive loss, had no visual or dexterity problems. He understood smoking may only take place at designated times; smoking accessories must be returned to and kept under control of the facility staff when not in use. He was labeled as safe to smoke without supervision.

A behavior nursing note dated 12/26/22 at 3:08 AM revealed Resident #2 was found to be smoking inside the building at 2:45 AM. The lighter was taken from Resident #2 and re-education was provided to him on the designated area to smoke and times. Resident #2 tolerated intervention and was escorted back to room. This note was documented by Nurse #2.

Resident #2 was not within 15 feet of an oxygen source at the time of the incident.

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An interview with Nurse #2 on 01/11/23 at 3:27 PM revealed she was familiar with Resident #2's care needs. She indicated another nurse found Resident #2 smoking, but Nurse #2 did not see him actively smoking. She stated the nurse told her to "come get your patient. I think he just lit a cigarette." She could not recall who told her Resident #2 was smoking. Resident #2 was in the inside of the building, in front of the smoking designation area doors. When she approached Resident #2, she did not see him smoke, but smelled cigarette smoke. He did not want to give her the cigarette box or lighter. He was re-educated on the smoking policy and was receptive to education in which he was receptive to giving her the cigarettes and lighter. She indicated she might have notified the Unit Manager of this incident and might have written the incident in the physician communication book.

Resident #2 was interviewed on 01/09/23 at 1:25 PM. He stated he was aware of the facility's smoking policy and had to smoke in the designated smoking area. He said had signed a Smoking Acknowledgement agreement in the past and he should keep his cigarettes and lighter at the nurses' station. He said he had to ask the nurses if he can smoke and was unable to recall the two incidents regarding him smoking within the facility.

The Unit Manager was interviewed on 01/11/23 at 4:16 PM. She stated she completed the Smoking Safety Screens for Resident #2 on 08/11/22 and 12/05/22. Each time she conducts a Smoking Safety Screen, she sits down with the resident, watches them light the cigarettes, smoke the cigarettes, and put out the cigarette. She indicated Smoking Safety Screens are completed

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F 689	Continued From page 62 quarterly or as needed. She indicated she would complete Smoking Safety Screens as needed if a resident harmed themselves while smoking. She stated an additional Safety Smoking Screen would not have been warranted if a resident was found smoking outside of the designated smoking area because she screens residents to determine if they are safe to smoke unsupervised. She stated Resident #2 received re-education on the smoking policy and was deemed a safe, unsupervised smoker. She indicated Resident #2 remained an safe, unsupervised smoker because he could light a cigarette, smoke it, and put it out independently. The Director of Nursing (DON) was interviewed on 01/09/23 at 1:57 PM. She stated the Smoking Safety Screens are expected to be completed at admission, quarterly, and whenever a resident changed their mind about smoking. She indicated the charge nurse, or the unit manager completes the Smoking Safety Screen. The Unit Manager completed Resident #2's Smoking Safety Screen, and she is responsible for determining if a resident is safe to smoke independently. Review of the Ad Hoc Quality Assurance and Performance Improvement documentation dated 12/05/22 revealed the problem indicated a resident was found smoking in room. The root cause analysis determined resident was found in possession of a lighter in their room. The action plan included: offending resident would be re-educated on safe smoking within the facility; current smokers would be re-educated on policies and procedures related to appropriate storage of lighters and matches; administrative staff would implement daily rounding focused on looking for ignition materials such as lighters and	F 689		

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F 689	Continued From page 63 matches; current smokers had been reviewed by Interdisciplinary Team (IDT) to assure current smokers continue to be safe to smoke at the facility; and any smoking materials found would be removed and placed in secure locations on nurses' station. The Ad Hoc Quality Assurance and Performance Improvement documentation was updated on 12/28/22 to indicate Resident #2 is to be checked after smoking for lighters.	F 689		