Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Woodlawn Haven Assisted Living
Address: 301 Craig Street Mount Holly, NC 28120
County: Gaston
License Number: HAL-036-006

II. Date(s) of Visit(s): 11/20/23, 11/30/23, 12/18/23, 12/27/23, 12/28/23, 01/11/24, & 01/17/24
Purpose of Visit(s): Complaint Investigation

Exit/Report Date: 01/17/2024

Instructions to the Provider *(please read carefully)*:

In column **III (b)** please provide a plan of correction to address *each of the rules* which were violated and cited in column **III (a)**. The plan must describe the steps the facility will take to achieve and maintain compliance. In column **III (c),** indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or an Unabated B violation**, this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation**, this agency *may* submit an Administrative Penalty Recommendation for the violation(s). When an Administrative Penalty will be recommended, the facility will have an opportunity to schedule a conference or submit additional information within **10 days** from the mailing or delivery of the Corrective Action Plan. If on follow-up survey the **Type A1 or Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty of up to $400.00 for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Unabated Type B, Citation)* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent**: *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: 10A NCAC 13F .0901 (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. Rule/Statutory Reference: Personal Care and Supervision Level of Non-Compliance: Type A1 Violation Findings: This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure supervision was provided for 1 of 1 resident (#1) who had a history of smoking while using oxygen, resulting in the resident's oxygen tank catching on fire and resident sustaining 2nd degree burns. The findings are: Per initial review of the facility's policy for use of tobacco revealed: 1. Designated smoking areas for residents are-in the back of facility, outside the activity room on patio (located off A and B halls). 2. Residents are not allowed to smoke in the front of building near loading and unloading zone. 3. Residents are to use ashtrays provided and not dispose of cigarette on the ground. 4. Smoking is not allowed in resident's bedroom or bathroom.	☐ POC Accepted _____ *DSS Initials*	February 16, 2024

5. Staff will monitor residents who smoke as needed.
6. Residents who use smokeless tobacco, (snuff, chewing tobacco, etc.), must use appropriate means of disposing. The facility reserves the right to confiscate all smokeless tobacco materials from resident if cleanliness becomes an issue.
7. The facility reserves the right to confiscate all smoking materials and /or issue a notice of discharge if resident fails to abide by smoking policies as to ensure safety for themselves and other residents.

Review of Resident #1's current FL-2 dated 01/13/23 revealed:
-Chronic Obstructive Pulmonary Disease (COPD), Carotid Artery Disease, and Atrial Fibrillation.
-She used oxygen continuous on 2 liters via nasal cannula.
-She was semi-ambulatory with a walker.
-She was totally dependent on staff for personal care assistance.

Review of Resident #1's care plan dated 11/02/23 revealed:
-She ambulated with a rollator walker.
-She used oxygen 2 liters via nasal cannula.
-She was oriented.
-She had an adequate memory.
-There was no documentation Resident #1 needed supervision while smoking.

Review of Resident #1's incident report dated 11/17/23 at 12:50pm revealed:
-Resident was outside smoking while using oxygen.
-Resident caught her face on fire.
-911 was immediately called.
-Resident was taken to emergency department (ED) for evaluation.

Review of Emergency Medical Services (EMS) report dated 11/17/23 revealed:
-Upon EMS arrival at 12:51pm Resident #1 was sitting outside of facility with several staff members around her.
-EMS staff assessed Resident #1 at 12:53pm.
-Resident #1 had a blackened face with second degree burns around the nose.
-Resident #1's eyebrows, eye lashes, and parts of her hair was singed away.
-Resident #1 stated she had Chronic Obstruction Pulmonary Disease (COPD) and had smoked while attached to nasal cannula (NC) oxygen.
-Resident #1 stated her face suddenly caught fire while smoking a cigarette.

-Resident #1 stated it took about 30 seconds to get the flames out.
-Resident #1's sleeves of her sweater were melted from extinguishing the flames from her face.
-Resident #1 complained of being short of breath.
-Resident #1 was administered non-rebreather (NRB) oxygen with abdominal pads between the mask and the face due to discomfort from the facial burn.
-Resident #1 had two IVs established and was administered Fentanyl for pain.

Review of emergency department admission dated 11/17/23 revealed:
-Resident arrived at the hospital at 1:22pm.
-Resident had medical history of Chronic Obstructive Pulmonary Disease (COPD) and seizures.
-Resident had facial burns sustained from smoking while wearing oxygen.
-Upon hospital arrival Resident was on 15 liters of oxygen using a non-rebreather mask (a type of oxygen mask that delivers a high concentration of oxygen and is used in emergencies such as smoke inhalation).
-Resident was short of breath and her airway was black.
-Resident appeared to have burns to the intraoral area as well as edema (swelling).
-She had partial thickness burns to the forehead, down the nose and soot in and surrounding the mouth.
-Resident #1 had first and second degrees burns.
-Resident was transitioned to Intensive Care Unit (ICU) in stable condition.

Interview with the Fire Marshal on 11/27/23 at 8:00am revealed:
-He responded to the facility on 11/17/23 at 12:47pm for Resident #1 who burned her face using her oxygen when she was smoking outside of the facility.
-Resident #1 was observed with a burned face, neck, and hair.
-The oxygen tubing was on the ground with some of Resident #1's hair still attached.
-Resident #1 had soot stains on the face, up the nostrils and down her throat.
-Resident #1 was asked to stick out her tongue. Her tongue rolled back instead of out.
-The tongue rolling back was an indication she would be intubated at the hospital.
-Resident #1 had 2nd degree burns to the face, esophagus, and lungs.
-Resident #1's airway was compromised.
-Smoking while wearing oxygen was dangerous because

oxygen supported combustion.
-Smoking while wearing a nasal cannula could cause fire to move more rapidly because of the tubing, which was wrapped around the ears and connected to the body.

Interview with Resident #1's mental health provider on 12/21/23 at 4:56pm revealed:
-She never observed Resident #1 smoking while wearing oxygen.
-She was not aware Resident #1 smoked while wearing oxygen until after the incident on 11/17/23.

Interview with Resident #1's primary care physician on 12/27/23 at 7:40am revealed:
-She was aware Resident #1 smoked while wearing oxygen.
-Facility staff had repeatedly told Resident #1 not to smoke while wearing oxygen.
-She had also informed Resident #1 not to smoke while wearing oxygen.
-Resident #1 was not given any suggestions regarding smoking while wearing oxygen.

Review of Resident #1's progress notes revealed:
-On 4/21/23, at 3:00pm Resident #1 was observed smoking while wearing oxygen.
-The Co-Administrator removed oxygen tank from Resident #1.
-The Co-Administrator explained the dangers of smoking with oxygen to Resident #1.
-Resident #1 stated she knew and would not bring the tank out again.
-There was no documentation that Resident #1 was provided supervision.
-There was no documentation of supervision being discussed with Resident #1.
On 6/19/23 at 3:00pm Resident #1 was observed smoking while wearing oxygen.
-Resident was informed by the Co-Administrator not to smoke while wearing oxygen.
-Resident #1 stated she understood.
-There was no documentation of the oxygen being removed from the smoking area.
There was no documentation that Resident #1 was provided supervision.
-There was no documentation of supervision being discussed with Resident #1.
On 11/17/23 at 8:30am the Resident Care Director (RCD) observed Resident #1 smoking while wearing oxygen at the front of the facility.

-Resident #1 stated the oxygen was turned off.
-The RCD informed Resident #1 she needed to leave the oxygen tank inside while smoking.
-The Resident #1 stated to the RCD she understood.
-There was no documentation of Resident #1 being educated on the dangers of smoking with oxygen.
-There was no documentation the oxygen was removed from Resident #1.
- There was no documentation that Resident #1 was provided supervision.
-There was no documentation of supervision being discussed with Resident #1.
On 11/17/23 at 12:50pm Resident #1 was sitting outside smoking while wearing oxygen and caught her face on fire.
-911 was immediately called.
-Resident #1 was transported to the emergency room for evaluation.
On 11/17/23 at 8:29pm Resident #1 was at a local trauma center.

Interview with a resident on 11/20/23 at 3:15pm revealed:
-He and Resident #1 were sitting outside at the front of the facility.
-Resident #1 rolled her oxygen tank outside with her, but she was not smoking.
-A few minutes later observed Resident #1's face and hair were on fire.
-She had a cigarette in her hand.
-He jumped up and started hitting Resident #1's face and hair to put out the flames.
-He did what he had to do to put out the flames.
-There were staff outside but not supervising Resident #1.
-The staff was at their cars.

Interview with a second resident on 11/20/23 at 3:50pm revealed:
-Resident #1 would come to the smoking area many days wearing oxygen.
-Every time Resident #1 came to the smoking area wearing oxygen a resident would immediately report it to a staff member.
-The staff member would come to the smoking area and tell Resident #1 she could not smoke while using her oxygen.
-The oxygen was removed from the smoking area.
-Residents were told not to take their oxygen to the smoking area.
-Staff did not supervise Resident #1 while smoking.

Interview with a third resident on 11/20/23 at 4:05pm

revealed:
-She heard staff multiple times inform Resident #1 not to smoke while using oxygen.
-When Resident #1 came to the smoking area wearing her oxygen residents would immediately report it to staff members.
-Staff members would come to the smoking area and remove the oxygen.

Interview with the facility transporter on 12/19/23 at 9:15am revealed:
-She witnessed Resident #1 on 11/17/23 sitting on the front porch with her oxygen with an unlit cigarette in her hand.
-She told Resident #1 she should not be smoking wearing oxygen.
-Resident #1 cursed her out and said she could smoke if she wanted to.

Interview with the Co-Administrator on 11/20/23 at 3:25pm revealed:
-She was in her office and a visitor came from outside and told her a resident was on fire.
-She ran outside and observed Resident #1 with a burned face.
-She observed Resident #1 with a partially smoked cigarette still in her hand.
-She did not observe the flames.
-Resident #1 stated she had the oxygen turned off when she was smoking.
-Staff members repeatedly warned Resident #1 she could not smoke with oxygen.
-Staff members informed Resident #1 not to go to the smoking area with her oxygen even if she was not smoking.
-When Resident #1 went to the designated smoking area other residents would report it to staff members.
-Staff members including herself would go to the designated smoking area and remove the oxygen.
-Resident #1 was not supervised because she was alert and oriented.

Interview with Co-Administrator on 12/18/23 at 4:10pm revealed:
-Resident #1 did not need to be supervised, she was alert and oriented.

Interview with Resident Care Director on 12/11/23 at 3:30pm revealed:
-She was in her office and a home health nurse stated Resident #1 was outside smoking wearing oxygen.
-She went out front and observed Resident #1 wearing

oxygen, but not smoking. -Resident #1 stated "I'm not smoking, I'm not smoking." -She informed Resident #1 she could not smoke while she was wearing oxygen. -Resident #1 stated she knew and understood. -She "may have" observed Resident #1smoking with her oxygen prior to 11/17/23, but just did not remember. -No resident ever reported to her Resident #1 was in the smoking area while using oxygen.		
The facility failed to supervise Resident #1 while smoking due to her history of smoking or attempting to smoke with her oxygen cannula on. This failure resulted in Resident #1's oxygen cannula catching fire and causing second degree burns to her facial and throat areas, having to be placed on mechanical ventilation and have a tracheostomy placed. This failure resulted in serious physical harm and neglect and constitutes a Type A1 Violation		
The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/20/23 and 12/18/23 for this violation. CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED 30 days from 01/17/2024.		

IV. Delivered Via:		Date:
DSS Signature:		Return to DSS By:

V. CAR Received by:	Administrator/Designee (print name):
	Signature: Date:
	Title:

VI. Plan of Correction Submitted by:	Administrator (print name):
	Signature: Date:

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ ***POC Not Accepted***	By:	Date:
Comments:		
☐ ***POC Accepted***	By:	Date:

Comments:

VIII. Agency's Follow-Up	By:	Date:
	Facility in Compliance: ☐ Yes ☐ No	Date Sent to ACLS:
Comments:		
**For follow-up to CAR, attach Monitoring Report showing facility in compliance.*		