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F 000	INITIAL COMMENTS A complaint survey was conducted from 02/17/20 through 02/25/20. Past-noncompliance was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The tags F689 constituted Substandard Quality of Care. Non-noncompliance began on 02/14/20. The facility came back in compliance effective 02/17/20. An extended survey was conducted.	F 000		
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 observations, a review of the facility video footage, record reviews, interviews with the emergency medical staff, fire department staff, facility staff, family member and the physician the facility failed to prevent a supervised smoker from having cigarettes and lighters in her possession and attempt to smoke while unsupervised for 1 of 9 residents (Resident #1) reviewed for smoking. Resident #1 exited the facility while unsupervised onto a breezeway outside the building in a wheelchair which was a non-designated smoking	F 689	Past noncompliance: no plan of correction required.	3/10/20

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

Electronically Signed | 03/10/2020

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area. While unsupervised Resident #1 attempted to ignite a lighter that she had in her possession to light a cigarette but sparks from the lighter caused the resident to catch fire. The resident was taken to the hospital for evaluation and treatment and found to have second-and-third degree flame burns on her head, neck, anterior trunk, bilateral upper extremities, and bilateral thighs. The resident died the following morning. The findings included:

The Smoking Policy read in part. It is the policy of this facility that smoking is not allowed in the facility by residents or staff. Residents are allowed to smoke outside in designated areas if the criteria outlined in the policy are followed ...The following interventions may be considered by the care plan team. C. Supervised smoking may be advisable if resident is not able to comprehend or follow the rules or if the resident disregards safety interventions. Supervised smoking should be scheduled by the care plan team and the resident. Efforts will be made to adhere to resident preferences but also allow for staff availability. The facility Smoking Policy did not address advising family members or visitors not to bring in any smoking materials and did not mention if residents could be searched for any hidden smoking materials.

Observations on 2/19/2020 at 11:30 AM revealed the facility ' s smoking times were posted at the 100/200 hall nurses station and on the 600 hall nurses station at 12:15 PM. The posted smoking times were listed as 9am, 11am, 1pm, 3pm, 5pm, 7pm, 9pm.
Resident # 1 was admitted to the facility on 8/11/16 and with diagnoses that included history of brain aneurysm with seizures, depression,

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polyneuropathy, arthritis, osteoporosis, anxiety and age-related nuclear cataract bilaterally. Resident #1 ' s most recent quarterly Minimum Data Set (MDS) dated 1/15/2020 revealed she was cognitively intact. She had clear speech, was understood and could understand. The resident ' s MDS did not reveal any behaviors including wandering. Resident #1 was coded as requiring extensive one person physical assistance with bed mobility and transfers. She was assessed as having upper and lower extremity impairment on one side and used a wheelchair for mobility. The MDS revealed she had skin damage with one burn and did not require the use of oxygen.

The Smoking Assessment completed on 10/23/2019 revealed, Resident #1 had no cognitive loss, was able to light, hold, smoke, dispose a cigarette safely. Resident #1 did not require supervision for safe smoking.

The Smoking Injury written by Nurse #1 completed on 1/13/2020 revealed, in part, Resident #1 had a 2 centimeter by 2 centimeter round burned area to upper left thigh with slough in the middle and redness around edges. Resident stated that she dropped her cigarette and burned herself while smoking outside last Monday. She stated that her daughter knew about it but she did not want staff to find out about it. The report revealed the resident was alert and oriented to person, place, time and situation.

An interview with nursing assistant (NA) #1 was conducted on 2/18/2020 at 3:40 PM. NA #1 reported on 1/13/2020 when she first saw Resident #1 ' s skin lesion on her upper inner thigh, she informed the resident she would need

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to immediately report the area to the Nurse. She stated Resident #1 was upset that she would be reported to the nurse and indicated that her family member was aware of the skin lesion. NA #1 reported Resident #1 was alert and oriented, aware of the facility smoking policy and should have reported her burn to staff immediately.

An interview was conducted with Nurse #1 on 2/18/2020 at 2:37 PM. Nurse #1 reported she was notified of Resident #1 ' s burn on 1/13/2020 by NA #1 who worked with Resident #1 that day. Nurse #1 reported Resident #1 had confirmed that she burned herself while out smoking and she had told her family member but did not report the burn to staff. Nurse #1 stated she completed a new smoking assessment that day and Resident #1 changed from an independent smoker to a supervised smoker. Nurse #1 reported she verbally informed Resident #1 she would be a supervised smoker and her cigarettes and lighter would now be stored on the nursing cart. Nurse #1 reported the resident had verbalized understanding of the change in her smoking from independent to a supervised smoker.

The nurse ' s note written by Nurse #1 at 12:59 PM on 1/13/2020 revealed, in part, Resident #1 was informed that she would be placed on supervised smoking, received education and would have a staff member present when she went out to smoke. She was also educated that all of her smoking materials lighters and cigarettes would have to be at the nurses ' station and dispensed by the nurse. Resident #1 verbalized understanding. The Responsible Party (RP) was informed of resident being placed on supervised smoking and to give cigarettes and

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smoking materials to nurse and the RP verbalized she understood the smoking policy.

The Smoking Assessment completed on 1/13/2020 revealed, in part, Resident #1 required supervision for safe smoking and smoking supplies should be stored at the nursing station. The report revealed the resident had a recent burn on her left thigh and failed to report it to staff for treatment. The interventions included having the resident on supervised smoking, Director of Nursing and Administrator meet with the residents ' responsible party on 1/21/2020 and discussed the supervised smoking policy and Resident #1 was not to have smoking paraphernalia in her possession.

An interview was conducted with the Director of Nursing (DON) on 2/19/2020 at 10:45 AM. The Director of Nursing stated the day NA #1 reported the burn to the nurse, Resident #1 had been giving herself her bed bath. The Director of Nursing reported Resident #1 was independent in her activities of daily living after staff set up her bath, she only required staff to wash her back and one arm. She stated Resident #1 tried to do as much for herself as possible and was able to turn and reposition herself in the bed. The DON specified Resident #1 had hid her burn from staff and only told her family member of the burn.

Resident #1 ' s care plan updated on 1/17/2020 revealed a plan of care was in place for the risk of further injuries related to her preference to smoke and had a recent burn to thigh from dropping cigarette ashes and not reporting the incident to staff. The care plan ' s goal was to minimize further smoking injuries. The interventions included staff supervision when smoking in the

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smoking area, the restrictions on smoking would be discussed with resident and to store smoking items (cigarettes, pipes, lighter, etc.) in a secure location such as the nursing cart.

A nurse ' s note written on 2/14/2020 by Nurse #5 revealed a family member of Resident #1 approached and gave Nurse #5 a pack of new, unopened, green pack of cigarettes for Resident #1.

A telephone interview was conducted with Resident #1 ' s RP on 2/25/2020 at 2:22 PM. The RP revealed she was aware of the burn to Resident #1 ' s thigh. The RP stated facility staff called her on 1/14/2020 to notify her of the burn to Resident #1 ' s leg, reviewed the smoking policy and informed her, Resident #1 was now supervised when smoking. The RP stated when Resident #1 became a supervised smoker she would give a pack of cigarettes to the nurse and if she took Resident #1 out herself, she would give the resident 2 cigarettes to hold and smoke. She stated when she knew Resident #1 was going out to smoke with staff, she would hand the resident 2 cigarettes to smoke while with the staff.

An interview with NA #4 was conducted on 2/18/2020 at 9:50 AM. NA #4 stated that staff would routinely check Resident #1 for cigarettes and if they found any in her fanny pack they would take them from her and tell the nurse. NA #4 stated on one occasion she found Resident #1 had a cigarette in her possession and she gave it to the nurse. NA #4 revealed it had been over two weeks since she had worked with Resident #1 and she did not remember when she had last seen Resident #1 smoking.

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An interview with NA #3, who cared for Resident #1 on 2/14/2020, was conducted on 2/19/2020 at 3:26 PM. NA #3 stated she was the NA assigned to Resident #1 during the time of the incident on 2/14/2020. NA #3 stated Resident #1 was in her wheelchair in her room when she came to work on second shift on 2/14/2020. NA #3 stated Resident #1 had been on the hall talking with staff before returning to her room for the evening meal. NA #3 stated the resident was in her room at 5:15 PM when she delivered her dinner tray. NA #3 stated the last time she saw Resident #1 was around 6:00 PM when she picked up her dinner tray, then went to assist other residents. NA #3 revealed usually Resident #1 would request to be taken out to smoke but that day she did not request to go out. NA #3 stated Resident #1 would sometimes try to "sneak" cigarettes and staff would remind her she was supervised smoker, take any smoking items the resident was trying to keep in her possession and report it to the nurse. NA #3 stated she had not seen Resident #1 with any smoking materials and NA #3 stated she was aware Resident #1 was a supervised smoker as she had a fall 30 days ago and the nurse told me that day, she was now a supervised smoker.

An interview with Nurse # 2 was conducted on 2/18/2020 at 11:50 AM. Nurse #2 stated on 2/14/2020 she was on the 200 hall when just after 7:00 PM she heard the code red for fire called. Nurse #2 stated she got the fire extinguisher and followed protocol by going to the 300 hall to check on residents there. She reported the fire was located off the 100/600 hall and smoke was noticeably thick on the 100 hall. Nurse #2 reported Resident #1 was in the room with her dinner meal when she provided her evening

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medications around 5:15 PM. Nurse #2 stated Resident #1 asked her to close the door on her way out, which was her usual request. Nurse #2 stated another nurse informed her Resident #1 was a supervised smoker after she received treatment for the burn to her thigh. Nurse #2 revealed a list of the supervised smokers was posted at each nurses ' station and staff were aware of which residents were supervised. Nurse #2 stated Resident #1 always came to her to ask for her cigarettes and her lighter.

A recording of the facility surveillance footage of the incident on 2/14/2020 was reviewed on 2/25/2020. In the video footage between 6:40 PM to 6:44 PM staff were observed on the 200 hall entering residents ' rooms with care items and closing a residents ' door. At 6:46 PM Resident #1 was observed to open her 200 hall room door and exit her room, no staff were seen on the 200 hall during this time. Resident #1 is seen to propel her wheelchair backwards past the 100/200 hall nursing station headed towards the 100 hall. In the 100 hall video footage staff are observed to enter residents ' rooms with care items and closing residents ' door. As Resident #1 is seen entering the 100 hall no staff were visible on the hall. Resident #1 exited the facility using the 100 hall exit door at approximately 7:06 PM and 100 hall staff are seen to exit residents ' rooms shortly thereafter carrying small bags of care items. Resident #1 is seen sitting alone outside the 100 hall door breezeway located between the 100 and 600 hall doors. In the video it appears Resident #1 attempts 5 times to light something close to her mouth. On the sixth attempt to light the object Resident #1 bursts into flames. In the video Resident #1 is seen outside on fire, then multiple staff are seen coming out in

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response to the fire.

A review of the nurse note written by the DON at 1:06 AM on 2/15/2020 revealed, in part, resident noted outside courtyard sitting in wheelchair with severe burns to head, face, upper torso, arms, hands, thighs. Staff had extinguished fire, 911 called. Residents clothing was removed immediately by numerous staff members and normal saline was applied to the resident ' s skin to moisten the burned areas. Once the resident was stable enough to be moved she was wheeled into the therapy gym. While in the therapy gym, the resident ' s skin was continued to be moistened with normal saline compresses, oxygen was applied and vital signs were taken. Blood pressure 214/112, pulse 94, oxygen saturation 95 %. Staff remained by resident until EMS (emergency medical service) and Fire Department arrived and exited the building. Director of Nursing notified Resident #1 ' s Doctor at 7:18 PM. Administrator notified the residents ' RP at 7:26 PM.

An Incident Audit Report for Resident #1 written by the Director of Nursing on 2/15/2020 revealed the Director of Nursing, Nurse Supervisor and other staff were alerted that there was a fire on the 600 hall. Director of Nursing and staff responded by running down 100 hall to exit through the corridor outside to 600 hall. DON and staff were unable to get to the door due to excessive smoke coming from outside into the 100 hall area. Director of Nursing ran to pull fire alarm and obtain fire extinguisher. Other staff members were coming down the hall with fire extinguisher. Director of Nursing exited the door at the end of 100 hall to see staff from 600 hall exhausting the fire. Resident ' s clothing was

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removed immediately by numerous staff members and normal saline was applied to the resident ' s skin to moisten the burned areas. Once the resident was stable enough to be moved she was wheeled into the rehabilitation gym. While in the gym, the resident skin was continued to be moistened with normal saline, oxygen was applied and vital signs were taken. Staff remained by the resident until EMS and Fire Department arrived and exited the building. Administrator notified the residents ' RP at 7:26PM.

The Investigation Guide written by the Administrator and DON on 2/14/2020 revealed Resident #1 was found upright in a wheelchair noted with burns and unresponsive. First aide was immediately provided by licensed nurses. The scene described Resident #1 was found in the breezeway outside between the 100 and 600 hall. Resident #1 was noted in a non-smoking area with flames noted to her clothing, both upper and lower extremities were noted with flames. Also noted on the scene were what appeared to be a pack of cigarettes, several lighters, a fanny pack and a soda can. The Root cause of the incident listed the resident was non-compliant with supervised smoking and was found to have hidden lighters in her possession/ on her body/ fanny pack. Her room was immediately searched for any unsecured smoking materials no cigarettes or lighters were found. All lighters were located on the resident.

An interview was conducted with the Director of Nursing on 2/19/2020 at 10:45 AM. She stated she was working in the conference room when the supply clerk ran in to tell her there was a fire on the 600 hall. The Director of Nursing and

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Nurse #5 ran towards the 100 hall and due to the amount of smoke filling the hall they could not reach the door. The DON stated she ran back to pull the fire alarm and ran back towards the 100 hall door. The Director of Nursing reported Nurse #5 had to kick to the door open and when she got outside, she saw 600 hall staff were outside responding to the code and had extinguished the fire. The Director of Nursing stated she called the Administrator to notify her of the fire. The Director of Nursing reported NA #2 was cutting off Resident #1 ' s clothing and fanny pack and pieces of clothing continued to smolder which staff extinguished. Resident #1 was burned from her fanny pack to her bottom. The DON reported staff continued to douse Resident #1 with saline to cool her skin. The Director of Nursing reported the resident never lost consciousness and when she was stable staff moved her to the therapy gym. She stated EMS arrived, assessed the resident, got her onto the stretcher and loaded her into the ambulance. The Director of Nursing stated she went out to the ambulance and EMS staff told her they were taking Resident #1 to the local hospital to be picked up by Life flight helicopter and flown to a Burn Center. The Director of Nursing indicated Resident #1 was aware of where the designated smoking area was located and to her knowledge never been on the 100 hall. The DON revealed Resident #1 had recently lost two family members, failed to report the burn to her thigh and was aware that she would lose her independent smoking privilege, when staff became aware of the cigarette burn. The Director of Nursing stated it looked like Resident #1 was wearing some type of puffy goose down jacket a sweat shirt, sweat pants and a bra. She reported it had been a typical day for the resident, she had not noticed any change or

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indication of depression after learning of the deaths of her two family members ' .

An interview was conducted with the Social Worker (SW) on 2/18/2020 at 3:10 PM. The Social Worker stated that she had clocked out and was walking to her car, when she heard someone yell. The Social Worker stated she saw someone with flames sitting upright in a wheel chair in the breezeway located between the 100 and 600 hall. The SW stated she ran back into building, saw flames out the 600 hall door and alerted staff to the fire. The SW stated she grabbed a fire extinguisher and ran out the 600 hall door to extinguish the fire. The Social Worker stated other 600 hall nurses ran out with fire extinguishers to extinguish the blaze. She stated more staff (not sure which staff) arrived, took her fire extinguisher and extinguished the resident. The Social Worker indicated she was not sure who had yelled, as the incident happened fast and all the staff responded quickly.

An interview was conducted with Nurse #3 via phone on 2/20/2020 at 3:36 PM. Nurse #3 stated she was working on the assisted living hall when a visitor came on the hall and yelled something was on fire outside. Nurse #3 revealed as she headed towards the 600 hall nurse station she could see flames out the therapy gym window and she alerted Nurse # 4 who was at the nurses ' station. Nurse #3 stated that Nurse #4 ran to the 600 hall door opened it, saw the flames told her to grab a fire extinguisher and Nurse #4 ran back inside to call 911. Nurse #3 stated she grabbed the fire extinguisher and ran outside. Nurse #3 stated she first thought a trash can was on fire then she saw an arm move and pointed the fire extinguisher towards the middle of a body.

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She indicated she stood 4 feet from the fire as she did not know if there was an oxygen tank involved and directed the fire extinguisher towards the middle of the body. Nurse #3 stated the blaze was so large she thinks she emptied two fire extinguishers putting out the fire. She stated she could see the person gasping for air, others around her were hollering but the incident happened so quickly she did know who they were. She stated the smoke and fumes were so thick she had difficulty breathing. Nurse #3 reported Resident #1 ' s face was scarred, her eyebrows were gone and she had about 3 inches of hair left on her scalp.

An interview was conducted with Nurse # 4 via phone on 2/20/2020 at 11:06 AM. Nurse #4 stated she was sitting at the 600 hall nurses ' station close to 7:04 PM when a visitor came on the hall and yelled something was burning outside. Nurse #4 stated she ran to the 600 hall door, looked out and saw someone was on fire in the breezeway. Nurse #4 ran inside, told Nurse #3 to grab a fire extinguisher and ran in the hall, grabbed another fire extinguisher, yelled at staff to call code red and ran outside to extinguish the fire. When she came back outside other staff (NA #2, Nurse #3) were extinguishing the fire, when the DON and Nurse #5 burst out the 100 hall door. Nurse #4 stated she continued to run back and forth bringing saline, handing to the Director of Nursing, Nurse #5 and NA #2 who cut the bags open and doused Resident #1 with saline and doused the blanket that was used to cover the resident. Nurse #4 stated someone said to move the resident into the therapy gym so she held up Residents #1 ' s feet while NA #2 pushed her wheelchair into the therapy gym.

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An interview was conducted with NA #2 on 2/20/2020 at 3:14 PM. NA #2 revealed he was in the break room when he heard code red called and ran towards the 600 hall location. NA #2 reported when he arrived Nurse #3 was in the process of extinguishing the fire. NA #2 stated he took over her fire extinguisher and helped put out the flames. NA #2 reported he ran to the 100 hall nurses station to retrieve his scissors and returned to cut off Resident #1 ' s jacket and clothing. NA #2 stated Resident #1 was wearing a silky type jacket with a hoodie and sweat clothes. NA #2 stated he instructed staff (did not know who) to bring a blanket as other staff were dousing the resident with saline. He reported someone then said to move the resident into the therapy gym so he pushed her wheelchair while Nurse # 4 held her feet up and they moved her into the therapy gym.

An interview was conducted with the supply clerk on 2/19/2020 at 11:11 AM. The supply clerk stated she was at the 600 hall nurse station when a visitor came down the hall and said there something on fire outside. The supply clerk stated when she ran out the 600 hall door she realized that someone was on fire. The supply clerk stated she ran through smoke to the conference room to notify the Director of Nursing of fire at the 100 hall door. She stated then ran to check on the 200 hall residents and discovered that Resident #1 was not in her room. The supply clerk stated she heard someone page to bring gauze and saline to the therapy gym, so she ran to the central supply room for the supplies and brought them to the therapy gym. The supply clerk stated she helped out for 10 minutes then returned to the hall to check on and instruct residents to stay in their rooms.

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An interview was conducted with Nurse #5 on 2/19/2020 at 3:20 PM. Nurse #5 stated that she and the Director of Nursing were working in the conference room when the supply clerk ran into announce a code red on the 600 hall. The Nurse #5 stated she and the Director of Nursing ran towards the 100 hall door and could not reach the door due to the amount of smoke filling the hall. Nurse #5 stated the Director of Nursing ran back to pull the fire alarm, she called 911 to report the fire and then proceeded to kick the 100 hall door open. Nurse #5 stated it was difficult to hear the 911 operator, as multiple staff members were outside yelling and calling for supplies. Nurse #5 stated she went back inside the 100 hall so she could hear the 911 operator and answer their questions. Nurse #5 stated the 911 operator informed her help was on the way and to wait outside to direct the emergency personnel to the resident. Nurse #5 stated she ran out the front door and over to the gate leading to the 100/600 hall breezeway. Nurse #5 stated a first responder arrived and she took him to the therapy room where Resident #1 had been moved. Nurse #5 stated by that time the fire truck and ambulance had arrived and facility staff moved aside to let the emergency personnel take over the situation.

An interview with the Administrator was conducted on 2/20/2020 at 1:39 PM via phone. The Administrator reported that according to the facility ' s video surveillance footage around 6:45 PM on 2/14/20 Resident #1 was noted to leave her room in her wheelchair and wheel herself backwards to the end of the 100 hall. The video footage showed Resident #1 exited out the door to the 100 hall breezeway. Next Resident #1 began to smoke, her clothing caught fire and

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shortly thereafter staff came out to assist her. The Administrator stated she received a phone call about 7:15 PM from the Director of Nursing making her aware of what had happened. The Administrator revealed that she used to be a burn nurse so she instructed the Director of Nursing to apply saline, call 911 and notify the fire department. The Administrator stated she instructed the Director of Nursing, after they extinguished the fire to move the resident to the therapy gym where they could lay her down in case she went into cardiac arrest. The Administrator stated staff provided simple first aid by keeping the resident moist and applied oxygen. The Administrator stated she called the residents ' RP at 7:26 PM and made her aware there had been an accident that involved Resident #1. The Administrator stated when she arrived to the facility she instructed staff to check all the residents ' rooms for any smoking materials like cigarettes and lighters and collected any smoking materials that were found. The Administrator stated between 10:45 PM and 11:00 PM she called the family member of Resident #1 for an update and left a message for them to return her call. At 11:23 PM she received a call back from a family member who stated they were at the Burn Center and Resident #1 had a 10-20 % change of survival, had severe burns and an inhalation injury. The Administrator stated that evening 100% of the staff working were in-serviced on the smoking policy, the smoking list was updated and posted at each nurses ' station. No smoking signs were posted outside the designated smoking area and new smoking signage was posted on all entrance/exit doors and halls informing visitors not to provide smoking materials to any resident.

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An observation was conducted with the Administrator of Resident #1 ' s wheelchair and charred fanny pack on 2/25/2020 at 11:20 AM. A bath basin held the melted remains of a fanny pack, a charred pack of cigarettes which was green in color, multiple bent cigarettes, 2 green lighters and a vertically split can were observed among the blackened charred remnants.

The Fire Department First Responder report dated 2/14/2020 revealed, in part, Patient clothes caught fire. Was extinguished by staff. Firefighters assisted EMS with burn patient, removed and taken from the facility.

An interview with the County Fire Chief was conducted on 2/21/2020 at 10:19 AM, via phone. The Fire Chief reported he was working on 2/14/2020 when they received a call to the Nursing Center. The Fire Chief stated when he arrived on the scene, staff had extinguished the fire. He stated the emergency medical service arrived at the same time and took control of the situation and the resident. The Fire Chief stated the fire departments role was to assist EMS with getting the patient prepared for the ambulance to transport to the hospital.

An interview was conducted with County EMS paramedic #1 on 2/20/2020 at 11:00 AM. Paramedic #1 reported when they arrived the patient was sitting upright in her wheelchair. Paramedic #1 reported they put a non-rebreather (oxygen mask that delivers oxygen at a half flow rate) applied burn sheets and got the resident onto the stretcher. Paramedic #1 reported the patient had full thickness burns and was burned from her head down to the top part of her upper legs. Paramedic #1 reported the patient was

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covered and taken to the ambulance where she was able to answer questions appropriately. Paramedic #1 reported the patient was taken to a local hospital to wait for Life Flight. However in route they received a call the Life flight was delayed and to go ahead into the hospital emergency department where the patient would be intubated. The paramedic reported she remembered it was unusually warm and windy that night.

An interview was conducted with County EMS paramedic #2 on 2/20/2020 at 11:05 AM. Paramedic #2 reported when they arrived the patient was seated-upright in a wheelchair and had burns from her kneecap to her head. Paramedic #2 reported there were several cut open and empty bags of saline on the ground and it looked like staff had tried to cool the patient down with saline. Paramedic #2 reported they wrapped the patient in burn sheets and moved her to the ambulance, where they started her on an IV solution and assessed her breathing. Paramedic #2 reported they were on the scene a total of 14 minutes before they headed to the local hospital where the patient was to be picked up by Life Flight. Paramedic #2 reported when they arrived at the local hospital, Life Flight advised them to take the patient into the ER for rapid intubation as her airway was compromised and their arrival was delayed. Paramedic #2 reported the patient was intubated in the ER and transferred to the Life Flight where she was to be taken to another area hospital burn center.

The Sheriff report revealed the report was dated 2/14/2020. The investigation report revealed a patient of the nursing center had been badly burned. Fire and EMS were on the scene while

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the Sheriff interviewed the staff, who reported a female resident had been outside smoking a cigarette and caught on fire.

The local hospital ER report dated 2/14/2020 at 8:16 PM revealed, in part, the patient was brought to the ER department by the local County EMS. For emergency load to Life flight transport to burn center. Patient began to decompensate with oxygen saturation dropping in route. Patient brought into emergency department for intubation and stabilization prior to flight. Patient intubated on arrival and Life Flight arrived just prior to intubation and patient was put on their monitor. The local hospital burn center admission note on 2/14/2020 revealed, in part, patient with mixed 2nd and 3rd degree flame burns to the head, neck, anterior trunk, bilateral upper extremities, bilateral thighs. After evaluation it was determined that surgery was not indicated. Patients ' wounds were extensive and the majority are third degree. A discussion with the family about goals of care due to extensive burn and the patient was made comfort care. The discharge disposition revealed, the patient expired on 2/15/2020 at 6:46 AM. The events prior to the death were bradycardia followed by cardiac arrest.

A corrective action plan for noncompliance developed by the facility and dated 2/17/2020 specified the following:

On 02.14.2020, 100% of identified smokers, 11 skilled resident smokers, were assessed by licensed nurses for any alterations in skin integrity that would indicate a potential burn, any residents found with skin integrity concerns resembling a burn. The weekly skin assessments will continue with no stop date.

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F 689	Continued From page 19 Results: None noted. Monitoring: Weekly skin assessments will continue for 100% of active residents and documentation will continue in the E-mar, assessments and documentation will be completed by the licensed nurse. Any skin lesion noted will be immediately reported to the licensed nurse for assessment, incident report, notifications of the physician, responsible party, and root cause analysis with updates the care plan, interventions to prevent recurrence. Any skin lesion determined to remotely resemble a burn will result in staff immediately initiating 1:1 staff supervision of the resident until no longer deemed necessary as evidenced by care plan updates and medical record documentation. On 02.14.2020 the Administrator posted notices to notify visitors not to give residents smoking materials to include lighters/cigarettes/vaping materials, but to give to staff for security. Signage posted on entrance doors, nursing stations, and other areas visible to visitors and family members. Results: Administrator and/or Director of Nursing daily rounds reveal signage posted on entrance doors, nursing stations, and throughout the facility. Monitoring: Daily monitoring to ensure signage continues to be posted on all entrance doors, nursing stations, and various other areas throughout the facility effective 02.14.2020. The monitoring will be completed by the Administrator and/or Director of Nursing or Manager on Duty in her absence.	F 689		

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2.14.2020 - 2.17.2020 100% of staff employed by Warren Hills Rehabilitation and Nursing Center were educated (employees included all clinical team members, department heads, therapy employees, dietary, housekeeping and laundry employees) regarding identified smoking residents included interviews related to other residents with the potential through observation to be in non-compliance with recommended supervised smoking based on updated smoking assessments. The education emphasized the intervention for violations of supervision of smoking to include immediate 1:1 supervision to be initiated and notification of the facility Director of Nursing and/or Licensed Administrator. 1:1 supervision is defined as one staff member assigned to one resident with constant supervision through observation. This education was completed by the Administrator and/or the Director of Nursing on or before 2/17/2020.

Updated smoking assessments completed by Administrator, MDS Coordinator, and Unit Manager on 2.15.20 and 2.16.20 identified a total of 11 skilled nursing identified smokers. The results of the updated smoking assessments reveal 9 out of 11 identified skilled residents who smoke require supervision by staff member during smoking sessions which will occur in the designated smoking area of the facility. Results: No further residents identified completed 2.17.2020

Monitoring will be completed daily along with facility assessments of secured smoking materials and resident compliance for those assessed to be supervised smokers. The monitoring will be completed under the direction of the Administrator by designated department

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heads.

On 02.14.2020 DON/Administrator and RN Unit Managers initiated education to ensure 100% of employees re-educated regarding facility smoking policy, smoking assessments, smoking care plans, supervised smoking and definition of what ' supervised ' smoking means for residents who are deemed as supervised during smoking and the staff role in ensuring residents who smoke are supervised for all smoking; location of communication for smoking residents (those identified as independent and those identified as supervised), with a list located at each nursing station (HIPPA protected), resident Kardexes which identify supervised versus independent based on each resident up to date smoking assessment, security of smoking materials for both independent and supervised smoking residents, immediate intervention of 1:1 supervision for any resident found to violate the smoking policy and reporting to the Administrator immediately the non-compliance and the 1:1 supervision initiated.

This same education will be added to the new hire orientation on 02.14.2020 and completed prior to working independently. Education includes: facility smoking policy, resident smoking assessment process, safe smoking interventions, storage of smoking paraphernalia and designated smoking area safety, definition of supervision of smokers (ensuring all residents identified per updated smoking assessments) are supervised by staff while smoking in designated smoking area located exterior to the facility, communication tools and location to refer to prior to providing any smoking materials to residents.
Results: 100% completed 02.17.2020

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Monitoring: The Administrator and/or Director of Nursing or designated department head in their absence will randomly monitor 10 staff members weekly, by quizzing and feedback of staff regarding the definition of supervision during smoking, return demonstration of determination of those designated as supervised smoking residents, security of smoking materials, and the urgency of immediate reporting of any residents who violate the required smoking supervision and/or security of smoking materials.
On 02.15.2020 and 02.16.2020:

100% of Responsible Parties of smokers, 11 skilled smokers in total identified, were called and educated by the Administrator/DON/or designee regarding the facility smoking policy with emphasis to not provide smoking materials to the residents, but rather provide to the nurses for proper storage and security. There was emphasis to discuss any violation of facility smoking policy would require 1:1 supervision for non-compliance. 1:1 supervision defined as 1 staff member assigned to one resident, who is deemed non-compliant through observation or daily assessments of security of smoking materials, with constant observation provided.

Any residents admitted beginning 02.14.2020, residents and responsible parties will be educated regarding the smoking policy by the Director of Admissions and/or the Administrator in her absence, to ensure understanding regarding adhering to the smoking policy and security of smoking materials and the importance of ensuring visitors/family members do not provide smoking materials to residents, those will be required to hand to licensed staff for validation of

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ensuring materials are properly secured.
Results: 100% of responsible parties verbalized understanding and compliance with policy.

Monitoring: Business Office Manager will audit every admission record beginning 2.15.2020 to ensure evidence of smoking policy review upon admission to the facility.

On 02.15.2020, 100% of smoking residents, which include 11 total skilled nursing smokers, were reviewed by the MDS Nurse to ensure all smoking assessments are accurate, up to date, and all smoking care plans are accurate and reflect the smoking assessments
Results: All current and completed 02.17.2020.

On 02.15.2020 and 02.16.2020, residents with a BIMS of 12-15 and above were interviewed by Licensed Nurse #2 and Nurse #3 to determine smoking status.
Results: 1 new smoker identified during facility wide reviews. Resident #2 was a newly admitted resident who did not disclose he smokes a cigarette when his son visits and he leaves the facility premises. Education provided regarding smoking policy and treated as all other routine smokers, this education was provided by Administrator.

On 02.15.2020 and 02.16.2020 and 02.17.2020 100% of alert/oriented x 4, smoking residents were re-educated by Nurse #5 and Nurse #6 and the Social Worker regarding facility smoking policy with emphasis on not providing any other residents smoking material for any reason, any violation by resident related to violation of policy will be immediately identified as a supervision smoker to ensure the safety of all other residents

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by visually monitoring violators do not have unsecured smoking materials in their possession with the potential to give to those identified as not safe to have in possession. Any subsequent violations would place the violator with 1:1 supervision initiated immediately.

Copies of smoking policies were provided to each smoking resident, 11 skilled smokers in total, by the Social Worker on or before 02.17.2020 with documentation noted in the Medical Record. Social Worker discussed the smoking policy with each resident and educated each resident, explaining and clarifying for return feedback of understanding and verbalization of intended compliance.
Results: 100% verbalize understanding and agreement with adherence to smoking policy.

Monitoring: Administrator and/or Social Worker in her absence will observe 100% of smoking residents weekly to ensure compliance, this monitoring will be ongoing with no stop date. Residents will be rotated in order to observe 100% of smokers each week for compliance.

On 02.14.2020 DON/Administrator and RN Unit Manager initiated education to 100% of all employees regarding the facility smoking policy, resident smoking assessment process, safe smoking interventions, storage of smoking paraphernalia, supervised smoking compliance by definition, and designated smoking area with staff presence for those identified as supervision smokers as stated previously in this document will be included in for all newly hired staff members in any department.
This same education will be provided to all new employees effective 02.15.2020 for all new hires;

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all education for new hires will be provided Director of Nursing and/or Administrator in her absence.
Results: 100% of education completed on or before 02.17.2020

Monitoring: Director of Nursing and/or Administrator will conduct weekly interviews of 10 random employees, quizzing them regarding their knowledge of the smoking policy, security of smoking materials, safe smoking interventions, designated smoking areas, interventions regarding violation of smoking policy and immediate reporting to Director of Nursing and Administrator. The monitoring will be ongoing with no stop date, until the QA team identifies the monitoring is no longer deemed necessary.
QA meeting held 2.17.2020 regarding discussion of the event, immediate steps of correction, education, facility assessments, and monitoring of all corrective actions, those in attendance were Administrator, Director of Nursing, MDS Coordinator, Clinical Nurse Consultant, Maintenance Director, Dietary Manager, Social Worker, Treatment Nurse, and Unit Managers/Support nurses. The information was also shared with Medical Director on 1.17.2020.

All monitoring was initiated immediately following completion of corrective interventions as state above, such as posting of signage, 100% staff education, facility assessments, 100% education of smoking residents, 100% education of smoking resident responsible parties, 100% of education of any newly admitted residents beginning 2.15.2020.

Monitoring Procedure:
Monitoring Procedures are listed above for each

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345240	A. BUILDING _____ B. WING _____	C 02/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN HILLS NURSING CENTER	864 US HWY 158 BUSINESS WEST WARRENTON, NC 27589

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 26	F 689		

intervention to ensure process improvement.

The Administrator and/or the Director of Nursing will ensure all monitoring is completed as stated for each intervention and the results of all monitoring are brought to the QAPI committee for review and adjustments in interventions based on the findings of the monitoring, this will be completed weekly X 4 then monthly X 3 and then quarterly thereafter.

Reports will be presented to the weekly QA committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly QA Meeting is attended by the DON, Wound Nurse, MDS Coordinator, Unit Manager, Therapy, HIM, Dietary Manager and the Administrator.
The Director of Nursing and the Licensed Administrator will be responsible for implementing the credible allegation.
The credible allegation initiated 2.14.2020 immediately following the stated event and completed 2.17.2020 with ongoing education and monitoring for any newly employed staff member upon hired prior to working independently and any newly admitted resident immediately upon admission to the facility. The QA committee will monitor compliance ongoing with no stop date.

The facility alleges full compliance with the plan of correction effective 2/17/2020.

As part of the validation process on 2/25/2020 the plan of correction was reviewed which included dates and content of the in services that were conducted, dates and content of the audits that were completed. A review of audits and dates of the skin assessment for all smokers for signs of

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F 689	Continued From page 27 any skin integrity concerns. A review of the dates and contents of in service education provided to all FT, PT, PRN department staff to include nurses, CNA ' s med aides, agency nurses/ CNA ' s and all department heads regarding the smoking policy. A review of the dates and content of questionnaires for all staff regarding the smoking policy. A review of the dates and content of education provided to all responsible parties of smokers. A review of the dates and contents or education provided to alert and oriented smoking residents regarding the smoking policy. A review of the dates of identified smokers who had their care plans reviewed and revised for smoking. A review of the dates and audits of daily signage posted. On 2/25/2020 the facility ' s compliance date of 2/17/2020 was validated.	F 689		