STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345236	A. BUILDING _____ B. WING _____	C 12/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILMINGTON	820 WELLINGTON AVENUE WILMINGTON, NC 28401

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F 000	INITIAL COMMENTS The survey team enterd the facility on 12/17/19 to conduct a complaint survey, and exited on 12/19/19. Additional information was obtained on 12/30/19. Therefore, the exit date was changed to 12/30/19. Immediate Jeopary was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 07/21/19 and was removed on 12/19/19. An extended survey was conducted.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		12/31/19

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

Electronically Signed | 01/08/2020

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F 656	Continued From page 1 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to develop a smoking care plan for 1 of 4 sampled residents (Resident #3) who smoked. Findings included: Resident #3 was admitted to the facility on 11/25/19. Her documented diagnoses included chronic obstructive pulmonary disease, syncope (fainting) and collapse, and anxiety disorder. Resident #3's 12/02/19 admission minimum data set (MDS) documented her cognition was intact, she exhibited no behaviors including resistance to care, she required staff assistance with her activities of daily living (ADLs) which ranged from	F 656	F656 Development of Comprehensive Care Plan 1. The care plan for Resident #3 was reviewed and updated on 12/18/2019 to reflect Resident□s preference for smoking with appropriate interventions to ensure safety while smoking by the MDS Coordinator. 2. An audit reviewing current resident care plans and interventions was completed to ensure smoking preferences were noted was completed on 12/18/2019 by MDS Coordinators. Care plans and interventions were reviewed and updated	

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F 656	Continued From page 2 supervision to dependence, she used tobacco products, and she received oxygen therapy. During an observation of the facility's designated smoking area on 12/17/19 at 10:42 AM Resident #3 was smoking cigarettes under the supervision of Personal Care Assistant (PCA)/Smoke Aide #1. During an interview with PCA/Smoke Aide #1 on 12/17/19 at 10:49 AM she stated Resident #3 was a dependent smoker. She explained that meant the resident had to be supervised at all times when she was smoking cigarettes in the designated smoking area. Review of Resident #3's care plan on 12/18/19 revealed that no problem, goal, or interventions had been developed to address the resident's safety while smoking. During an interview with Minimum Data Set (MDS) Nurse #1 on 12/19/19 at 4:50 PM she stated Resident #3 should have a care plan which addressed smoking. She reported she thought one was not developed because the resident's 12/04/19 smoking assessment mistakenly documented, "previously smoked." According to MDS Nurse #1, all residents who smoked should have a care plan which provided interventions on how to keep the residents safe. During an interview with the Director of Nursing (DON) on 12/19/19 at 5:02 PM she stated all residents who smoked were supposed to have a smoking care plan which provided details about how to care for the residents and keep them safe while they were smoking.	F 656	by the MDS Coordinator. 3. Education was provided by the Corporate MDS Coordinator to the MDS Coordinators and Interdisciplinary staff members on updating care plans of Residents who prefer to smoke and interventions to ensure safety are care planned on 12/18/19. 4. An audit of all Residents who prefer to smoke will be audited weekly for 4 weeks to ensure smoking care plans and appropriate interventions in place will be completed by the Interdisciplinary Team and MDS Coordinator. Audit results will be presented by MDS Coordinators to the Interdisciplinary Team and reviewed during the monthly Quality Assurance Meeting for 3 months. Results of the QAPI will be maintained by the Administrator. 5. December 19, 2019	

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F 689	Continued From page 3	F 689		
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 observation, physician interview, physician assistant (PA) interview, staff interview, and record review the facility failed to put effective interventions in place to prevent 1 of 4 sampled residents (Resident #1) who smoked from sustaining smoking-related burns to his mouth, pharynx (cavity behind the nose and mouth, connecting them to the esophagus), and toes. It had been reported previously to supervisors at least 13 times that the resident was smoking unsupervised with his oxygen running in areas not designated for smoking. After sustaining burns in the nursing home the resident was sent to the local hospital which then transferred him to a hospital burn unit. The resident spent three and a half months in the burn unit, and was then transferred back to the local hospital. In addition, the facility failed to ensure that 1 of 4 sampled residents (Resident #3) who smoked had a "No Smoking, Oxygen in Use" sign posted at her room door. Immediate Jeopardy (IJ) began on 07/21/19 when the facility failed to enforce their smoking policy, and Resident #1 began smoking unsupervised in undesignated areas with his oxygen on. IJ was	F 689	F689 Free of Accidents Hazards/Supervision/Devices 1. Resident #1 was taken by ambulance to the local hospital and transferred to the burn unit of a nearby University Hospital where he was treated and recovered. Resident #1 did not return to this facility. 2. A complete review of residents who reside in the facility was completed by the MDS Coordinator on 12/19/19 which identified all residents who are smokers. For each smoker a new Safe Smoking Assessment was completed under the supervision of the Director of Nursing on 12/19/19 with each resident provided a risk designation of 1) independent smoker- no apron necessary, may light own cigarettes, 2) dependent smoker □ must wear protective smoking apron, must have cigarette lighted by smoking aid, may need to have cigarette held while smoking if unable to hold cigarette on own, or 3) Supervised smoker- must wear protective smoking apron, may light own cigarette, may hold own cigarette. Any	12/31/19

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F 689	Continued From page 4 removed on 12/19/19 when the facility implemented an acceptable credible allegation of IJ removal. The facility remains out of compliance with this tag at a lower scope and severity level of "D" (no actual harm with potential for more than minimal harm that is not immediate jeopardy) for example 2. Findings included: The facility's "Smoking Policy", which was revised in July 2017, revealed the following: Policy Statement: "This facility shall establish and maintain safe resident smoking practices." Policy Interpretation and Implementation: "1. Prior to, and upon admission, residents shall be informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences. 2. Smoking is only permitted in designated resident smoking areas, which are located outside of the building. Electronic cigarettes may be permitted inside in designated areas only. Otherwise, smoking is not allowed inside the facility under any circumstances. 3. Oxygen use is prohibited in smoking areas ....6. The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. If a smoker, the evaluation will include: a. Current level of tobacco consumption, b. Method of tobacco consumption, c. Desire to quit smoking, if a current smoker, d. Ability to smoke safely with or without supervision (per a completed Safe Smoking Evaluation). 7. The staff shall consult with the Attending Physician and the Director of Nursing Services to determine if safety restrictions need to be placed on a resident's smoking privileges based on the Safe Smoking	F 689	new admission will have a smoking assessment completed within 24 hours of admission to identify smoking designation by the Director of Nursing or administrative nurse. All identified smokers had their Care Plans reviewed and updated as necessary to designate whether they are Independent, Dependent or Supervised smokers on 12/19/19 by the MDS Coordinator. 3. The Smoking Policy- Residents was reviewed by the QAPI Safety Committee on 12/19/19 to assure it correctly represented the safety plans intended for all smoking residents. The designations of Independent Smoker, Dependent Smoker and Supervised Smoker were updated to clarify interventions expected to occur for each smoker, along with the training requirement for the Smoking Aid. Current facility staff have received in-service on Smoking Policy □ Resident, including each designation and associated intervention by the DON and/or Administrative Nurses 12/19/19. This will be included as a part of facility orientation for all new employees. A notification has been posted at the front entrance to educate family members and visitors that any smoking material should to be delivered to the Nursing Supervisor for storage in each resident□s lock box for security. This policy has been added to our admission process for all new residents. All smokers are in-serviced on 12/19/19 by the Administrator and/or Director of	

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F 689	Continued From page 5 Evaluation. 8. A resident's ability to smoke safely will be re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by staff. 9. Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. 10. The facility may impose smoking restrictions on a resident at any time if it is determined that the resident cannot smoke safely with the available levels of support and supervision. 11. Any resident with restricted smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking ....13. Residents are not permitted to give smoking articles to other residents. 14. Residents without independent smoking privileges may not have or keep any smoking articles, including cigarettes, tobacco, etc, except when they are under direct supervision ...." 1. Resident #1's 08/16/18 hospital Discharge Summary documented, "Inhalation injury, burn injury to oropharynx. Patient was smoking while wearing oxygen which resulted in a tank explosion on 08/05/18, flame flashed in his face which resulted in some oropharynx burns-sent to (hospital) burn unit ....singed facial hairs around the lips, some soot present on the tongue, blistering to the hard palate concerning for second-degree burns ....As a result of this incident his home was destroyed by fire and he is now homeless." Record review revealed that Resident #1 was admitted to the facility on 08/16/18. His documented diagnoses included respiratory	F 689	Nursing regarding the Smoking Policy-Residents focusing on safe smoking strategies specific to designations, the requirements for strict adherence to smoking times and areas and the management, the strict prohibition of use of any oxygen or oxygen supplies in the vicinity of smokers, and storage of smoking materials. The smoking aid was in-serviced on 12/19/19 about the requirement to remain with smokers during designated smoking times, to assure each has the required supervision and assistance necessary and to assure that all smoking materials are returned to the lock boxes when smoking time is over. According to the policy update, the Smoking Aid and or designee will be in-serviced at least quarterly and more often if concerns are identified. Effective 12/19/19, the Smoking aid will have an up to date list of all smokers with their designation of Independent, dependent or supervised noted by their name and clearly defined on the list heading with what each designation requires. All oxygen users were identified and listed on 12/19/19 by the Director of Nursing. Each identified resident will have a magnetic sign adhered to their bedroom door that states Oxygen in Use. For those oxygen users who are smokers, the same or similar sign has been attached to their wheelchair if they have one. 4. An audit of all Residents who prefer to smoke will be audited weekly for 4 weeks for 2 months than quarterly, to ensure smoking care plans and appropriate	

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F 689	Continued From page 6 conditions due to smoke inhalation, chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), and major depressive disorder. On 09/17/18 Resident #1's smoking assessment documented he had cognitive loss and dexterity problems, and liked to smoke 1 - 2 cigarettes in the afternoon. The assessment determined he was safe to smoke only with supervision. On 09/26/18 Resident #1's care plan, which was in place on 07/21/19, identified "The resident is a dependent smoker" as a problem. Interventions for this problem included, "Continue to cue and educate (resident) on dangers of smoking with 02 and continue to offer cessation. Instruct resident about smoking risks and hazards and about smoking cessation aids that are available. Instruct resident about the facility policy on smoking: locations, times, safety concerns. Monitor oral hygiene. (Resident) requires supervision while smoking. Notify charge nurse immediately if it is suspected resident has violated facility smoking policy. Observe clothing and skin for signs of cigarette burns." Resident #1's 04/25/19 quarterly minimum data set (MDS) documented his cognition was intact, he exhibited no behaviors including resistance to care, he required staff assistance that ranged from supervision to dependence with his activities of daily living (ADLs), and he was receiving oxygen therapy. Review of Resident #1's July 2019 physician orders revealed he had an order for continuous oxygen at 3 liters per minute per nasal cannula.	F 689	interventions in place will be completed by the Interdisciplinary Team and MDS Coordinator. The facility Administrator and DON will complete random rounds monthly for 3 months and then quarterly for 2 quarters. A summary of audit results will be completed by the facility Administrator and presented at the facility monthly QAPI meeting, to ensure continued compliance. 5. December 19, 2019	

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In a 07/21/19 1:56 PM progress note Nurse #1 documented, "Resident (#1) was noted to be sitting outside on front porch smoking while wearing O2 (oxygen) two times, once by supervisor and once by Speech Therapy. This nurse educated resident both times on the dangers of smoking while utilizing O2. Resident verbalized understanding."

During an interview with Nurse #1 on 12/17/19 at 11:53 AM she stated Resident #1 quit smoking after a hospitalization in April 2019, but was found on the front porch of the building smoking unsupervised on 07/21/19 with his oxygen running. She commented Resident #1 told her that he had started smoking again, and was not interested in cessation. According to Nurse #1, she told Resident #1 that she needed his smoking supplies, and he stated that he only had the cigarette which he was in the process of smoking. Nurse #1 reported another staff member caught the resident smoking on the front porch with his oxygen on 30 minutes later, and again the resident insisted that he only had the cigarette which he was smoking. She commented the supervisor was requested to talk to the resident about his abuse of the smoking policy, and this supervisor may have collected smoking supplies off the resident. However, Nurse #1 stated she never saw any more smoking supplies on Resident #1 after 07/21/19. She reported Resident #1 was alert and oriented so she felt searching his room and person for smoking supplies was a violation of his rights. Nurse #1 commented she had a talk with Resident #1 telling him that smoking with his oxygen on was putting himself and the other residents in the facility in extreme danger. She explained the resident shook his head that he

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understood, and stated he would comply with the smoking policy; smoking in the designated area, letting the nurses keep his supplies, and not smoking with his oxygen in use.

In a 07/21/19 3:47 PM progress note Nurse #2 documented, "Resident noted by staff to be outside in front of building smoking several times today with his oxygen on. Resident educated on smoking safety and instructed that he may smoke safely in designated areas only and he must remove his oxygen while smoking. Resident educated on the dangers to himself and others that smoking with oxygen could potentially cause. Resident instructed to notify staff when he wants to go outside to smoke so staff may remove his oxygen during that time and reapply it upon entering the building after smoking. Resident asked to turn over his smoking supplies to his nurse on the hall per our smoking policy. Resident verbalized understanding."

During a telephone interview with Nurse #2, a weekend supervisor, on 12/17/19 at 1:29 PM she stated she was asked to address Resident #1 at least once, possibly twice, about smoking on the front porch of the building (not the designated smoking area) and smoking with his oxygen on. She reported she never collected any smoking materials from the resident because he denied having any supplies other than the cigarettes he was smoking at the time. However, she commented she told the resident that he needed to turn over any smoking materials which would be kept in a lock box until he needed them when smoking in the designated smoking area. She remarked she also educated the resident about the dangers of smoking with oxygen on, and the resident stated he understood what he was being

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told.

During an observation on 12/19/19 at 9:05 AM there were two "no-smoking" signs on the front porch, a placard posted on the glass vestibule surrounding the front door, and the other a computer-generated sign in a stand on the front porch. When facing the exterior of the exit door on Resident #1's hall there was a commercial sign warning "No smoking beyond this point" on the left side of the building six to eight feet away from the door itself.

Resident #1's 07/21/19 smoking assessment documented the following information: he was currently smoking, he intended to smoke, he did not wish to stop smoking, the resident smoked at least 10 times daily, the resident had a history of smoking related incidents, he did not exhibit signs of confusion, he could make himself understood, he demonstrated understanding of the facility's smoking policy/times and place allowed for smoking/policy for storage of smoking materials, his vision was adequate with glasses, the resident did not have dexterity problems, no adaptive equipment was necessary when smoking, the resident could hold a cigarette safely, the resident used supplemental oxygen, the resident could not safely be without oxygen during smoking times, and the resident could not extinguish cigarettes safely.

During an interview with Nurse #3 on 12/17/19 at 2:21 PM he stated Resident #1 was alert and oriented, smoked on and off after a home incident, and was discovered smoking with oxygen on in July 2019 on the front porch. He reported he only saw smoking supplies on the resident once, and thought it might have been a

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couple of days after the 07/21/19 incident. He explained when the resident opened a dresser drawer in search of a pen or pencil two cigarettes were in view. Nurse #3 stated he removed the cigarettes, and re-educated the resident that he could not keep smoking materials on his person or in his room.

A 07/22/19 psychotherapy consult documented " ...staff reported/documented concerns regarding patient (Resident #1) being found twice over the weekend sitting outside on the front porch smoking while his oxygen was on. Each time patient was educated on the seriousness of this and he gave up his smoking materials. Staff reported that patient seemed unconcerned about the danger of his behaviors even though the reason for his admission to this facility is because of explosion and fire in his home started by his smoking with oxygen. Patient maintains that his oxygen was not turned on even though staff reports that this is not true. Also, patient apparently stated repeatedly that smoking with oxygen was not dangerous, despite his previous history. Patient was rather argumentative today when confronted about this. He presents with constricted affect but denied any worsening of depression or anxiety. He denied any thoughts of self-harm. Patient is cognitively intact and was reassured that if he wants to go smoke, staff will make accommodations for this, namely without him using oxygen while smoking. Patient voiced understanding and will alert staff when he wants to smoke. Focus of session was offering patient support and validation of feeling while exploring ways in which he might improve safety while smoking, per his choice. I spoke with nursing staff about this and they will make arrangements for patient to switch wheelchairs to go outside

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without oxygen when he would like to smoke. Patient responded well to this intervention with mood being stable at end of session."

During a telephone interview with Resident #1's psychotherapist on 12/18/19 at 5:03 PM he stated the resident was in complete denial, stating he was not smoking in unsupervised areas with his oxygen on, and then commenting that there was no danger from smoking with oxygen running. He reported the resident had a "you can't tell me what to do" attitude. According to the psychotherapist, he educated Resident #1 that it was his right to smoke as long as he followed the facility's smoking policy. He stated the resident did not have dementia, and did not exhibit suicidal ideation. He reported he continued to educate Resident #1 about the dangers of smoking with oxygen on during follow-up sessions in early and mid-August 2019. He commented people had the right to make bad decisions.

Resident #1's 07/25/19 annual MDS documented his cognition was intact, he exhibited no behaviors including resistance to care, staff assistance with ADLs ranged from supervision only with toileting/dressing/transfers/walking in room and corridor/and locomotion on and off unit to dependence on staff for bathing, the resident currently used tobacco products, and the resident was receiving oxygen therapy.

On 07/29/19 Resident #1's care plan problem was updated to reflect, "I continue to be a dependent smoker. At times non-compliant with smoking policy." Goals for this updated problem were, "I will not smoke without supervision through the review date. I will not suffer injury from unsafe smoking practices through the

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review date." No new interventions were developed for this problem and no interventions were revised for this problem after they were initially developed on 09/26/18.

In a 08/07/19 9:59 PM progress note Nurse #4 documented, "(Resident #1) found outside smoking with O2 on at 3 L (liters). Resident educated multiple times regarding smoking and diagnosis."

During an interview with Nurse #4 on 12/18/19 at 3:15 PM he stated he had not observed Resident #1 smoking with his oxygen on, but was informed of such behavior by several care providers. He reported he found the resident outside a lot on the front porch and on the side of the building outside his hall exit door, and he was suspicious the resident was smoking unsupervised. He commented the facility's Social Worker (SW) and nurse supervisors educated the resident about his violations of the smoking policy.

In a 08/08/19 11:12 AM progress note the facility's SW documented, "Spoke with (Resident #1). Went over the smoking policy with the resident (copy was given). There is a designated area for smoking, and we are asking you to let a nurse know (when) you want to smoke. It is not safe for you to smoke with your oxygen on. 'Okay I will follow the rules.'"

Record review revealed the SW had Resident #1 sign on 08/08/19 that he had been educated on the facility's smoking policy, and how he had violated that policy.

In a 08/20/19 2:16 PM progress note the SW documented, " (Resident #1) is not following

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smoking policy/schedule/designated place to smoke. It was brought to this writer's attention that (resident) was smoking out front. This writer spoke with (resident) and went over the smoking policy again."

Record review revealed the SW had Resident #1 sign on 08/20/19 that he had been educated on the facility's smoking policy, and how he had violated that policy.

During an interview with the facility's SW on 12/17/19 at 11:42 AM she stated Resident #1 was unhappy that he had to be supervised and hand over his smoking supplies. She commented she completed group in-servicing about the facility's smoking policy with residents who smoked and their family members on 05/15/19, but she was not sure if Resident #1 attended since she did not think he was actively smoking at that time. The SW stated if residents remained non-compliant with the smoking policy the facility tried to involve the family and re-educate the residents. The SW reported she left voice mails and talked with a family member of Resident #1 about his inability to follow the smoking policy. According to the SW, the family member commented she would try and talk with the resident, but she was not sure she would have any success because the resident seemed to be determined to smoke with oxygen his oxygen on as he did in his own home.

During an interview with the Director of Nursing (DON) on 12/18/19 at 10:18 AM she stated Resident #1 smoked for a little while in the facility and was compliant with the smoking policy, but then had a COPD exacerbation, quit smoking, and started back up without informing staff. She reported the resident began smoking

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unsupervised outside of the designated smoking area, and began smoking while his oxygen was running. She commented the main intervention used to try and keep Resident #1 safe was education by various different people including the psychotherapist, SW, nurses, and a nurse/friend. According to the DON, Resident #1 was placing himself and other residents in danger by smoking without supervision with his oxygen running. She reported smoking assessments were completed initially and then quarterly for residents who were actively smoking. She stated when the resident started defying the smoking policy in late July 2019, the facility asked the resident where he was getting his smoking supplies, but the resident refused to reveal the source. According to the DON, when residents failed to follow the smoking policy, staff were instructed to inform management when they found infractions and what transpired. She stated Resident #1 was very alert and oriented so the staff educated the resident about the dangers of smoking with his oxygen on, and staff were told to keep a close eye on the resident since he was smoking outside the designated smoking area, but this seemed to irritate the resident. She reported the facility's SW also attempted to find Resident #1 placement in other nursing homes which might have a more liberal smoking policy. She commented the facility did not give the resident a 30-day discharge notice although they would have been justified since the resident failed to follow the smoking policy multiple times after he was re-educated about how he was breaking it. According to the DON, the facility did not like to resort to giving many 30-day discharge notices, and the facility chose to react to Resident #1's smoking misbehavior with compassion since he was making friends in the facility and becoming

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more social after being admitted in a withdrawn state. She also stated the resident had burned his home down while smoking with oxygen on so if the facility discharged him, there were few choices where the resident could reside.

During a follow-up interview with the DON on 12/18/19 at 1:21 PM she stated the direct care staff were asked by the supervisors to keep a close eye on Resident #1 after it became apparent he was having problems following the smoking policy, but this extra supervision was not quantified and staff members weren't officially assigned to check on the resident at certain intervals. She stated dependent smokers were educated that they could not keep smoking supplies on their person or in their room, including Resident #1. She commented numbered lock boxes were kept for each dependent resident so the Personal Care Assistants (PCAs)/Smoke Aides could get their smoking supplies for the residents as they headed out onto the smoking porch.

During an interview with Nursing Assistant (NA) #1 on 12/17/19 at 2:29 PM she stated Resident #1 was very alert and oriented, and was able to travel throughout the building in his wheelchair. She reported she never saw the resident with smoking materials on him or in his room. She commented it was difficult to keep an eye on the resident because he was independent with his ADLs and could navigate his wheelchair about the building when she was providing ADL care to other residents.

During an interview with NA #2 on 12/17/19 at 4:19 PM she stated Resident #1 was alert and oriented and in and out of his room a lot in the in

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the last 3 - 4 months. She reported the resident was very independent, and did not rely on staff. She commented staff could tell the resident something, he would nod like he understood, but would not always do what he had been told. She stated she did not see smoking materials on the resident or in the resident's room.

During an interview with NA #3 on 12/17/19 at 4:32 PM she stated Resident #1 was very alert and oriented, and she did not see any smoking materials on the resident or in his room. She reported the resident did his own ADLs, dressed himself, took care of his own hygiene so she did not get a close look at his person, and she did not search his room for cigarettes because the resident was alert and oriented and informed that he could not keep his own smoking materials. She commented it was difficult to keep watch over Resident #1 since the NAs usually had at least ten residents to care for on their assignments.

During an interview with NA #4 on 12/18/19 at 1:40 PM she stated Resident #1 was in and out of his room and could move quickly in his wheelchair. She reported it was difficult to keep an eye on him when she was trying to provide care to the other residents on her assignment. She commented the resident smoked on and off during the time she cared for him, but she never saw any smoking supplies on him.

During a 12/18/19 11:14 AM interview with Nurse #6, the former 3 - 11 supervisor who held the position during the time that Resident #1 was not following the smoking policy, she stated staff reported to her over ten times that the resident was smoking with oxygen on, unsupervised, in an

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area not designated for smoking. She reported Resident #1 was alert and oriented and able to make his own decisions. She commented he was independent with care and transfers, and could navigate in the building and outside in his wheelchair. She reported she mostly found the resident smoking out on the front porch of the facility which was a no-smoking area. She remarked that one time she found him smoking with his oxygen on in front of the generator on the front porch which was very dangerous since the generator fumes, lit cigarette, and oxygen could have blown the building up. She stated other than the lit cigarettes she found the resident smoking, the only other smoking supply she found on the resident was a lighter which he dropped when she approached him, but Resident #1 refused to tell where he got the lighter or cigarettes he was smoking. However, Nurse #6 stated that she had heard from other staff that a family member of the resident was bringing him the smoking supplies. She reported she personally did not confront this family member, but had a conversation with another family member who stated she might see if the resident would be willing to give up regular cigarettes for e-cigarettes, but the family member never got a chance to do so because the resident was hospitalized in late-August 2019. According to Nurse #6, she also offered to take the resident out to the designated smoking area if he needed to smoke, but he continued to smoke with his oxygen on in undesignated areas.

During a 12/19/19 10:42 AM phone interview with Nurse #7, former 7 to 3 supervisor, she stated she was told by staff three times that Resident #1 was smoking unsupervised in an undesignated area with his oxygen on. She stated she

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educated the resident that he could burn himself and harm other residents by smoking with his oxygen on. She explained Resident #1 would state that he understood, reporting he would not smoke with his oxygen on any more, and he would apologize. She stated she reviewed the facility's smoking policy with Resident #1 when he decided he was going to smoke for the first time in the facility, and again when the policy was revised due to changes in the smoking times. However, she reported she could not remember whether she had the resident sign and dates these policies. She stated it would have been good if the facility could have tracked the resident's whereabouts, but the facility could not use a Wanderguard on the resident because he was alert and oriented. She stated the resident was followed by psychiatric and psychotherapy services for depression, and they discussed his smoking non-compliance with him. According to the supervisor, when Resident #1 decided he was no longer going to follow the smoking policy, he became very sneaky in about a four-week period, seeming to plan quick trips outside to smoke unsupervised with his oxygen on. She stated it was difficult for staff to keep track of him. She reported Resident #1 had a couple of male friends who signed him out and took him off campus, and when the resident was found smoking cigarettes unsupervised with oxygen on, she talked with the visitors. She commented she educated them that it was okay to buy smoking supplies for the resident if he insisted, but the supplies needed to be turned into nursing so they could be locked away in a lock box.

In a 08/26/19 2:32 AM progress note Nurse #5 documented, "Overheard alarms going off and walked the halls to investigate. Approached

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(Resident #1's room) and smelled burned smoky odor. Noted toilet was completely blackened and filled with soot, melted nasal cannula on floor, burned tiles on floor, cigarette butt noted floating in toilet and standing in the bedroom floor was a shakened, burned resident."

In a 08/26/19 2:40 AM progress note Nurse #5 documented, "Removed (Resident #1) from bedroom, removed oxygen tank from bedroom ....Emergency services treated and transported resident to emergency room. Fire Department assessed the area for safety and smoke damage."

During a telephone interview with Nurse #5 on 12/30/19 at 10:01 AM she stated she had limited contact with Resident #1 since she only worked every other weekend on night shift. She reported the resident was in his room most of the night, maybe coming out occasionally for ice and sodas. She commented the resident appeared to be alert and oriented. According to Nurse #5, she had never personally seen the resident smoking in undesignated areas or smoking with his oxygen on. However, she stated she was told by another staff member that he was found outside the building in an undesignated smoking area smoking with his oxygen on during her shift. She reported she had not seen any smoking materials on Resident #1 or in his room. She commented she also heard from other staff members that Resident #1 was bumming cigarettes off other residents in the facility who smoked. Nurse #5 stated she heard the resident's smoke alarm sound on 08/26/19, and when she got to his bathroom there was a cigarette butt in his toilet, the toilet set was blackened, and his nasal cannula was burnt up. She reported it appeared

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the resident had tried to stomp out fire in his sock feet. She explained she could not determine the extent of his burns because there was so much smoke debris and soot around his eyes, nose, the palms of his hands, and the soles of his feet.

A 08/26/19 Change in Condition form documented, "Burn of mouth and pharynx, respiratory condition due to smoke inhalation, hypoxic, smoking in the bathroom, O2 in use, aerosol can in use. Burns and smoke inhaled. Face: swelling and redness around eyes, nose and mouth. Right toe burns noted on lateral aspect of foot and toes, left toe burns noted on inner aspect of toes. Resident was smoking while having oxygen in use and using an aerosol deodorant can. Cigarette butt found in toilet. Toilet blackened."

08/26/19 hospital records documented, "Facial burn-per EMS pt (patient) is coming from nursing home. Patient was caught smoking in the bathroom at the facility, oxygen caught on fire, now has soot around nostrils and singed hairs in moustache. Pt also has soot and burns to bilateral toes. Pt is usually at 3 liters, is currently on 4 liters and 93% (oxygen saturation) ....presents to the emergency department after his nasal cannula caught on fire ....Now has soot in his nostrils and around his nose with a burned moustache. He also has burns to his bilateral feet from attempting to put out the nasal cannula with his feet. Patient has difficulty breathing through his nose ...Physical Exam: Soot and 2nd and 3rd degree burns in the bilateral nares (nostrils). Burns to the upper lip and moustache ....Patient transferred to (hospital burn unit) without incident. Multiple bedside evaluations. Continues to protect his airway with no significant

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respiratory distress. At one point in the emergency department I did move his nasal cannula to his mouth rather than his nose as his nares are completely obstructed by soot and scarring at this point ...."

During an interview with the facility's Staff Development Coordinator (SDC) on 12/17/19 at 11:24 AM she stated she completed a facility-wide in-service about the smoking policy, involving all disciplines, on 08/26/19. Handouts from the in-servicing documented, "Residents must turn in all cigarettes and lighters when entering the building! All smoking materials must be locked up. No exceptions! No borrowing lighters and cigarettes. Any violations will be reported to administration. Smoking hours: 8:00 AM - 8:00 PM. Riverwalk (hall off which the facility's designated smoking area was located) only. Smoking times: 9:00 AM, 11:00 AM, 1:00 PM, 3:00 PM, 5:00 PM, and 7:00 PM. All smokers will be supervised during smoking without exception. Smoking is only allowed in designated smoking areas. No person shall be permitted to smoke while wearing oxygen, with an oxygen tank/concentrator on or near their chair or with any oxygen source within the designated smoking area. (Riverwalk smoking area)." She also reported she in-serviced the nursing staff about 30-day discharge notices on 08/26/19. She explained Resident #1 qualified for such a notice because he repeatedly violated the smoking policy, but the facility did not want to take such action against a resident who was homeless and who had made many friends in the facility.

During an interview with the facility's SW on 12/17/19 at 11:42 AM she stated she completed in-servicing about the facility's smoking policy

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with all residents who were active smokers and their family members on 08/26/19.

During an interview with the DON on 12/18/19 at 10:18 AM she stated after the 08/26/19 incident two packs of cigarettes were found in one Resident #1's dresser drawers. However, she reported the facility did not incorporate smoking accidents into their QA program because the problem with Resident #1 was an isolated incident, and there had been no problems with other smokers following the smoking policy.

During a follow-up interview with the DON on 12/18/19 at 5:32 PM she stated the interdisciplinary approach to solving Resident #1's problem with smoking was demonstrated during care plan meetings. She explained during these meetings the resident was asked why he continued to smoke with his oxygen on, but he could not explain why. The resident did comment that he wanted to smoke more frequently than was allowed. According to the DON, the root cause of the resident's behavior seemed to be an addiction which was out of control, and the resident made an informed decision to remain non-compliant. She reported the interventions were to continue to have a variety of people educate the resident about the dangers of smoking with his oxygen on, and to try and keep a close eye on the resident's whereabouts.

Duringa telephone interview with Physician #1 on 12/18/19 at 4:20 PM he stated he was aware that Resident #1 had blown his home up by smoking with his oxygen running. He also reported facility staff informed him that the resident had resumed smoking while in the facility, but he commented he did not recall being made aware that the

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resident was smoking with his oxygen on. However, he stated one of the other doctors or the Physician Assistant (PA) in the group might have been informed. This physician stated Resident #1was very addicted to smoking, and he was not sure there was any way to stop him from smoking. He reported hearing staff mention they thought a family member was bringing the resident smoking supplies. He commented it would have been a violation of resident rights to search the resident's room for the supplies. According to the physician, he thought the power of addiction was making the resident more devious in his smoking efforts. He stated the danger of being burned when smoking with oxygen was very high, with that danger increasing when attempting to smoke with oxygen inside.

During an interview with PA #1 on 12/19/19 at 9:58 AM she stated she was aware that Resident #1 was not following the smoking policy. She reported she was also aware that repeated education about the dangers of smoking with oxygen on was provided to the resident, and she was aware that the SW attempted to find another nursing home for the resident. She commented she did not know what else the facility could have done to prevent the resident from eventually sustaining burns in the facility. According to the PA, she talked to the resident herself, and he told her that he was not going to smoke any more. She commented that smoking while oxygen was running was very dangerous and explosions were possible.

The Administrator and DON were notified of the Immediate Jeopardy on 12/19/19 at 11:35 AM.

On 12/19/19 at 5:55 PM the facility provided an

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acceptable credible allegation for IJ removal.

The facility's credible allegation for IJ removal for the deficiency at F689 included the following information:

F689
Credible Allegation of Removal of Immediate Jeopardy
Summary in Response to the Allegation of Immediate Jeopardy
On 8/26/2019, resident #1 went into his bathroom wearing his nasal cannula and apparently lit a cigarette. It appears that the oxygen which had collected in the cannula ignited causing the resident to suffer burns to his face and both feet from pulling the canula off and dropping it onto his feet. Smoke alarms sounded and staff responded immediately removing the resident from his bathroom and initiating first aid while calling for emergency services. Resident was taken to the local hospital by ambulance and transferred to a burn unit where he recovered but did not return to this facility.
Resident #1 has a Brief Interview of Mental Status (BIMs) of 14 on a scale of 0-15 with 15 being the highest level of cognitive function measurable on this scale and had been repeatedly educated on the dangers of smoking with oxygen. According to record review, resident had began smoking outside of designated times and areas and occasionally with oxygen running beginning on 7/21/19. Multiple interventions had been implemented in effort to promote the safety of this resident while honoring his choice to continue to smoke despite his diagnosis of Chronic Obstructive Pulmonary Disease and use of continuous oxygen. Interventions included, but were not limited to, multiple sessions by Social

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Work and Nursing for personal 1:1 education on the dangers of using oxygen while smoking, Psychotherapist counseling to determine why resident stated oxygen had not been running when it had, Smoking cessation opportunities and encouragement, multiple sessions of education on the smoking policy addressed to resident, family and friends (who were believed to be providing resident with smoking materials), education on the requirement of leaving all smoking materials in the numbered lock box for which only the charge nurse held the key, multiple smoking assessments, attempts to relocate resident to another nursing facility, personal contact with family members to remind not to provide smoking materials, increased supervision of resident, offers of use of E-Cigarettes, in-service training of all staff, residents and family members on safe smoking policy. Despite these efforts, resident was found smoking with oxygen in place two times on 7/21/19, again on 8/7/19, again on 8/20/19 and on 8/26/19 at which time it resulted in igniting the nasal canula with injuries to resident #1 as stated above.

Identify those residents who have suffered or are likely to surfer a serious adverse outcome as a result of the non-compliance:

Resident #1 was taken by ambulance to the local hospital and transferred to the burn unit of a nearby University Hospital where he was treated and recovered. Resident #1 did not return to this facility.

A complete review of residents who reside in the facility was completed by the MDS Co-Ordinator on 12/19/19 which identified all residents who are smokers. For each smoker a new Safe Smoking Assessment was completed under the supervision of the Director of Nursing on 12/19/19 with each resident provided a risk designation of

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1) "independent smoker"- no apron necessary, may light own cigarettes, 2) "dependent smoker" - must wear protective smoking apron, must have cigarette lighted by smoking aid, may need to have cigarette held while smoking if unable to hold cigarette on own, or 3) "Supervised smoker"- must wear protective smoking apron, may light own cigarette, may hold own cigarette.
All smokers had their Care Plans reviewed and updated as necessary to designate whether they are Independent, Dependent or Supervised smokers on 12/19/19 by the MDS Coordinator.
Specify the Action the Entity will take to Alter the Process or System Failure to Prevent a Serious Outcome from occurring or reoccurring and when the action will be complete:
The "Smoking Policy- Residents" was reviewed by the QAPI Safety Committee on 12/19/19 to assure it correctly represented the safety plans intended for all smoking residents. The designations of "Independent Smoker", "Dependent Smoker" and "Supervised Smoker" were updated to clarify interventions expected to occur for each smoker, along with the training requirement for the Smoking Aid.
Current facility staff have received in-service on "Smoking Policy - Resident", including each designation and associated intervention by the DON and/or Administrative Nurses 12/19/19.
A notification has been posted at the front entrance to educate family members and visitors that any smoking material needs to be delivered to the Nursing Supervisor for storage in each resident's lock box for security.
Smoking aides are available 7 days per week, 8am to 8pm.
All smokers are in-serviced on 12/19/19 by the Administrator and/or Director of Nursing regarding the "Smoking Policy- Residents"

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focusing on safe smoking strategies specific to designations, the requirements for strict adherence to smoking times and areas and the management, the strict prohibition of use of any oxygen or oxygen supplies in the vicinity of smokers, and storage of smoking materials. The smoking aid was in-serviced on 12/19/19 about the requirement to remain with smokers during designated smoking times, to assure each has the required supervision and assistance necessary and to assure that all smoking materials are returned to the lock boxes when smoking time is over. According to the policy update, the Smoking Aid will be in-serviced at least quarterly and more often if concerns are identified.
Effective 12/19/19, the Smoking aid will have an up to date list of all smokers with their designation of Independent, dependent or supervised noted by their name and clearly defined on the list heading with what each designation requires.
All oxygen users were identified and listed on 12/19/19 by the Director of Nursing. Each identified resident will have a magnetic sign adhered to their bedroom door that states Oxygen in Use. For those oxygen users who are smokers, the same or similar sign has been attached to their wheelchair if they have one.
Allegation of Immediate Jeopardy removal:
The facility alleges immediate jeopardy removal as of 12/19/19.

Validation:

Immediate Jeopardy (IJ) was removed on 12/19/19 at 7:55 PM. Validation of the credible allegation for IJ removal was completed as evidenced by reviewing new smoking assessments for seven residents currently

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residing in the facility who smoked. The picture board of smoking residents was reviewed with 2 residents identified as independent smokers, 5 residents were identified as dependent smokers, and no residents were currently identified as supervised smokers. Updated care plans were reviewed for the seven smoking residents. The revised smoked policy was reviewed, and the signs to be posted at the front doors warning that all smoking materials had to be delivered to the unit supervisors were observed. The list of smoking residents and their smoking classifications, which was to be provided to the PCAs/Smoke Aides daily, was reviewed. The list of residents using oxygen was used to verify that all of these residents had "No Smoking/Oxygen in Use" signs posted at their room doors. An ad hoc meeting of the facility's QA committee was observed. Eleven staff members (4 nurses, 3 NAs, 1 PCA/Smoke Aide, Rehabilitation Director, Admissions Director, and 1 Med Aide) and the seven smoking residents in the facility were interviewed about the revised smoking policy, and all were able to articulate the changes in the policy.

2. Resident #3 was admitted to the facility on 11/25/19. Her documented diagnoses included chronic obstructive pulmonary disease, syncope (fainting) and collapse, and anxiety disorder.

Resident #3's 12/02/19 admission minimum data set (MDS) documented her cognition was intact, she exhibited no behaviors including resistance to care, she required staff assistance with her activities of daily living (ADLs) which ranged from supervision to dependence, she used tobacco products, and she received oxygen therapy.

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A 12/08/19 physician order started Resident #3 on oxygen at 2 liters per minute via nasal cannula to keep oxygen saturation above 90%.

During an observation of the facility's designated smoking area on 12/17/19 at 10:42 AM Resident #3 was smoking cigarettes under the supervision of Personal Care Assistant (PCA)/Smoke Aide #1.

During an interview with PCA/Smoke Aide #1 on 12/17/19 at 10:49 AM she stated Resident #3 was a dependent smoker. She explained that meant the resident had to be supervised at all times when she was smoking cigarettes in the designated smoking area.

On 12/18/19 at 9:09 AM Resident #3 was in her room, but there was no "No Smoking/Oxygen in Use" sign posted at her doorway.

During an interview with Nurse #8 on 12/18/19 at 9:16 AM she stated all residents who used oxygen, no matter whether the oxygen was continuous or as needed, should have "No Smoking/Oxygen in Use" signs posted by their room doors. She reported these signs served as reminders to residents and visitors that smoking in the presence of oxygen was very dangerous. She commented that if these signs were not posted this created a risk for everyone in the building since oxygen and lit cigarettes together could create explosions.

During an interview with Nurse #3 on 12/18/19 at 9:50 AM he stated all residents who had continuous or as needed oxygen were supposed to have "No Smoking/Oxygen in Use" signs posted at the doorways to their rooms. He could

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F 689	Continued From page 30 not explain why Resident #3 had no sign by her door, and did not know how long this resident had been without a sign. During an interview with the Director of Nursing (DON) on 12/19/19 at 5:02 PM she stated all residents who received any oxygen were to have magnetic "No Smoking/Oxygen in Use" signs posted at their doorways to remind everyone that smoking in the presence of oxygen posed a safety risk.	F 689		