STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345133	A. BUILDING _____ B. WING _____	C 03/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILKESBORO	1000 COLLEGE STREET WILKESBORO, NC 28697

(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 000	INITIAL COMMENTS The survey team entered the facility on 02/25/21 to conduct an unannounced complaint investigation survey and exited on 02/26/21. Additional information was obtained through 03/05/21. Therefore, the exit date was changed to 03/05/21. There were twelve allegations investigated and three were substantiated resulting in deficiencies. Event ID # E3DC11. Past noncompliance was identified at: CFR 483.25 at tag F-689 at a scope and severity of (J). The tag F-689 constituted Substandard Quality of Care.	F 000		
F 561 SS=E	An extended survey was conducted on 03/05/21. Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the	F 561		3/6/21

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

Electronically Signed | 03/23/2021

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F 561	Continued From page 1 facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview, the facility failed to allow residents who were assessed to be a "safe smoker" the ability to smoke independently per their individual preference due to the facility policy requiring all residents to be supervised during smoking activities for 7 of 9 residents assessed for preferences (Resident #2, #3, #4, #5, #6, #8, and #9). Findings included: A review of the facility document titled "Resident Smoking" reviewed/revised 10/22/20 indicated on page 1 of 2 the facility provides a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and non-smoking residents. It further indicated safety measures for the designated smoking area will include, but not limited to 5. All residents and family members will be notified of this policy during the admission process, and as needed. 6. Residents will be asked about tobacco use during the admission process, and during each quarterly	F 561	F561- Self Determination 1. A root cause analysis was completed on 2/25/21 in regard to the facility□'s failure to ensure resident self-determination. Residents #2, 3, 4, 5, 6, 8 and 9 stated their smoking preferences were not being met. The administrator, director of nursing, social worker, activity director, maintenance director, therapy director, and personal care assistants discussed individually with each smoker preferences on 3/2/21. All smokers have access to smoke at any time in the designated smoking area. 9 out of 9 of the smoker□s preferences are now met and continual discussions with the residents in regard to preference will be ongoing to ensure regulatory compliance. 2. All in-house smokers have the potential to be affected therefore all smokers were interviewed individually on 3/2/21 by administrator to ensure resident rights with smoking and self-determination were in regulatory compliance. All newly	

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F 561	Continued From page 2	F 561		

and comprehensive Minimum Data Set (MDS) assessment process. 7. Residents who smoke will be further assessed, using the Resident Safe Smoking Assessment, to see if any residents are safe to smoke at all. 8.Any resident who is deemed safe to smoke, WILL BE SUPERVISED, will be allowed to smoke in designated smoking areas (weather permitting), at designated smoking times, and in accordance with his/her care plan. 9. If a resident who smokes experiences a decline in condition or cognition, he/she will be reassessed for ability to smoke independently and/or evaluate whether any additional safety measures are indicated. 10. All safe smoking measures will be documented on each resident's care plan and communicated to all staff, visitors, and volunteers who will be responsible for supervising residents while smoking. Supervision will be provided as indicated on each resident's care plan. 12. If a resident or family member does not abide by the smoking policy or care plan (e.g. smoking materials are provided directly to the resident, smoking in non-smoking areas, does not wear protective gear), the plan of care may be revised to include additional measures such as room searches, prohibited smoking, or even discharge.

A review of a Quality Assurance Performance Improvement (QAPI) dated 1/29/21 provided by the Administrator during the entrance conference indicated "smoking" was an area of concern and smoking times had been modified to reflect all residents would be supervised while smoking and at designated times of 8AM, 10AM, 1PM, 3PM 5PM, and 7PM daily.

An observation on 2/25/21 at 7:30 PM revealed signage on the courtyard designated for smoking

admitted smokers self-determining needs will be addressed upon admission.
3. The systemic changes that were put into place to ensure the deficient practice does not recur is the revised smoking schedule. The administrator initiated education on the regulation self-determination to all staff on 2/25/21 and completed education on 3/5/21. Supervised smokers have a smoking aide in the designated smoking area daily with additional duties in regard to infection control and smoking safety monitoring implemented 3/4/21 from 7a-11a, 12p-5p, and 6p-9p to ensure the smoker can determine the frequency and duration of their smoking breaks per their preferences. Safe smokers have 24-hour access to their smoking materials and are able to smoke any time per their preference. During the hours that the smoking aide is not continually monitoring, any of the following staff (certified nursing assistant, licensed nurse, certified medication aide, personal care assistant, activity aide, or department head) can supervise the smokers and access smoking materials.
4. To ensure residents have the right to make choices about aspects of his/her life in the facility that are significant to the resident, the QAPI committee initiated random interviews on 3/2/21 to be completed on four different residents weekly for four weeks then 1x monthly for three months for follow-up and recommendations for continuation as indicated to ensure the specific deficiency cited remains corrected and in

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that indicated smoking times were 8AM, 10AM, 1PM, 3PM, 5PM, and 7PM.

An observation was made on 2/25/21 beginning at 7:30 PM and ending at 8:00 PM revealed 8 residents and 1 staff member (Patient Care Aide-PCA #1) seated in the designated smoking area smoking and socializing. Seven of the eight residents were seated in their wheelchairs and one resident (Resident #8) was ambulating in the area then, he was observed to sit on a bench next to Resident #5. Each smoker was given two cigarettes from their smoking locker, PCA #1 was observed to light resident's cigarettes and sit on the picnic bench for approximately 30 minutes while observing the resident smoking activities.

An additional observation was made on 2/26/21 at 10:30 AM revealed 7 residents in the smoking courtyard with PCA #2. Resident #8 was observed to be ambulating throughout the entire smoking area socializing and lighting other resident's cigarettes. PCA #2 was observed to be ambulating throughout the smoking courtyard for approximately 15 minutes while he interacted with each resident and observed their smoking activities.

1. Resident #2's "Safe Smoking Assessment" dated 1/11/21 revealed he was assessed to be able to smoke independently.

Resident #2's smoking care plan dated 2/1/21 revealed he may smoke independently per smoking assessment.

An interview with Resident #2 on 2/25/21 at 5:00 PM revealed he was very upset when he was informed he would only be able to smoke six

compliance with the regulatory requirement.
Compliance date of 3/6/2021

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times per day and must be supervised while smoking due to another resident who had an accident while smoking. Resident #2 stated, "I am responsible when I have smoked, and I was the one who ensured the oxygen was turned off immediately following the accident that occurred. I try to watch out for myself and other people when I am outside in the smoking area and should not be punished." Resident #2 explained smoking was something that helped calm his nerves and not being allowed to smoke when he felt anxious effected his recovery to transition back home. He further revealed he had been made to feel like he was stuck inside four walls like a prison cell without his privileges to smoke when he wanted. Resident #2 revealed he was used to smoking right before bed to help him relax and sleep, but at home if he woke up during the night he would smoke another cigarette and be able to go back to sleep and now he was no longer able to sleep as well.

2. Resident #3's "Safe Smoking Assessment" dated 10/8/20 revealed she was assessed to be able to smoke independently.

Resident #3's smoking care plan dated 2/1/21 with a revision date of 2/10/21 revealed she may smoke independently per smoking assessment.

An interview with Resident #3 on 2/26/21 at 3:08 PM revealed she was told she had to be supervised while smoking after a facility accident involving smoking had occurred and that she was only allowed to smoke 6 times per day which was less frequently than she wished, but she had to go then or not be allowed to smoke at all.

3. Resident #4's "Safe Smoking Assessment"

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dated 07/04/18 revealed she was assessed to be able to smoke independently.

Resident #4's smoking care plan dated 6/24/20 revealed she may smoke independently per the smoking assessment. An additional smoking care plan dated 2/1/21 revealed Resident #4 may smoke independently per smoking assessment.

An interview with Resident #4 on 2/26/21 at 10:30 AM revealed she had difficulty expressing herself vocally but was able to shake her head to yes/no questions and nod her head yes and shake her head no when asked how many times per day she was allowed to smoke while interviewer held up finger increasing by one until a nod was provided. Resident #4 indicated she could smoke 6 times per day. Resident #4 also indicated by a head nod that she was supervised by staff for smoking.

4. Resident #5's "Safe Smoking Assessment" dated 01/07/21 revealed she was assessed to be able to smoke independently.

An interview with Resident #5 on 2/26/21 at 10:15 AM revealed she was not feeling well that morning and stayed in bed during the designated smoking time however she had been assessed to be an independent smoker and now had to be supervised for smoking and wanted to be able to smoke at any time since she was assessed as a safe smoker.

5. Resident #6's "Safe Smoking Assessment" dated 10/28/20 revealed he was assessed to be able to smoke independently.

An interview with Resident #6 on 2/26/21 at 10:30

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AM revealed he was a smoker in the facility and indicated he had been assessed to be a safe smoker, but had to currently be supervised by staff while smoking due to another resident having an accident involving smoking. Resident #6 expressed smoking was one of the only pleasurable activities he enjoyed, and it made him angry that his rights were taken from him but said "what do you do? Not follow the rules and then not be able to smoke at all. First, they took away our ability to smoke at night as we wished and now, we can only smoke while being babysat six times a day. Why can't we be allowed to make decisions for ourselves as adults?

6. Resident #8's "Safe Smoking Assessment" dated 12/01/20 revealed he was assessed to be able to smoke independently.

An interview with Resident #8 on 2/26/21 at 10:30 AM revealed he had been assessed to be a safe smoker but his privilege to smoke independently was removed when the facility initially told him they would be locking the doors to the smoking area at 8:30 PM nightly and he would not be allowed to smoke until after breakfast in the morning. Resident #8 indicated he had been smoking a very long time and it was something he could find enjoyment with while having to reside at the facility. Resident #8 stated we've been locked in here and not able to socialize for a while now because of the virus and now they have taken away our ability to go smoke which allowed us to go outdoors to enjoy the fresh air and relax while we enjoy a few cigarettes. He explained smoking was the only activities he had while in the facility and recently, the facility had told him that he must be supervised and only smoke during the six designated times during the

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F 561	Continued From page 7 day. Resident #8 further revealed he has to eat cold breakfast if he eats at all because his breakfast tray is being served shortly before the time to smoke and he has to make a choice to eat and miss his opportunity to smoke or not be allowed to smoke that time. He elaborated to say, "Smoking is more important to me!" 7. Resident #9's "Safe Smoking Assessment" dated 09/04/20 revealed he was assessed to be able to smoke independently. An interview with Resident #9 on 2/25/21 at 09:40 AM revealed he was unhappy that he couldn't go to smoke like he used to be able to. Resident #9 indicated the facility had limited his ability to smoke to six times per day and now he must be supervised, and he was not allowed to manage his own smoking materials. Resident #9 stated they took our keys away from us and now we are only given two cigarettes at a time and sometimes he doesn't even know how many cigarettes he has left in his locker until he had almost ran out because a staff member must hand them to him. Resident #9 stated "why can we not be treated like adults in this place?"	F 561		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical,	F 580		3/6/21

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mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).

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F 580	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff, and medical provider interviews, the facility failed to notify a physician of an acute change in status immediately following an acute burn sustained by Resident #1 when he was involved in an accident involving smoking while wearing oxygen for 1 of 1 resident reviewed for notification of the medical provider (Resident #1). Findings included: Review of the medical record of Resident #1 revealed he was admitted to the facility on 11/10/20 with diagnoses that included acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD) and dependence on supplemental oxygen. Resident #1's admission Minimum Data Set (MDS) dated 11/13/20 revealed Resident #1 required supervision to two person staff assist for transfers, was cognitively intact, and used oxygen while a resident. A nurses' progress note documented by Nurse #1 dated 1/28/21 revealed Resident #1 was smoking with his oxygen tank on the back of his wheelchair and his nasal cannula intact to his nostrils bilaterally which ignited a flame and caused Resident #1 to be burned on his upper lip, nose, left side of cheek, left eyelid, and left eyebrow. An interview conducted on 2/25/21 at 5:55 PM with Resident #1 revealed he had suffered burns to his face following a smoking incident he was involved in approximately a month ago. Resident	F 580	F580- NOTIFY OF CHANGES 1. A root cause analysis was conducted on 2/25/21 and completed on 3/4/21 to identify the root cause of the facility□s failure to notify the medical director of the incident with resident #1. The root cause analysis was determined by Administrator, Director of Nursing, Unit Manager, Hall nurse, and Medical Director. The results of the root cause analysis were reviewed on 3/1/21 with QAPI committee and incorporated in the facility□ plan of correction. All nurses were immediately educated and measures were put into place on 3/1/21 to ensure the facility consults with the medical director with resident changes and to notify the resident representative when there is a change of status that requires notification. All new hires will be trained on notifying of changes. 2. All residents have the potential to be affected, therefore an audit was completed by the interdisciplinary team (Administrator, Director of Nursing, Activity Director, MDS Coordinator, Unit Managers, and wound care nurse) was completed on 3/1/21 to ensure all recent changes that would result in physician notification were completed from 2/1/21 to 3/1/21 to ensure regulatory compliance. 3. All certified nursing assistants and licensed nurses were educated on the notification of changes. Education was initiated by administrator and director of nursing on 2/25/21 and completed 3/4/21. The education focused on notifying	

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F 580	Continued From page 10 #1 explained on the night of the accident, he had arrived at the smoking area shortly before the time for designated smoking time to end, felt rushed as he hurried and self-propelled his wheelchair past NA #1 who was standing in the doorway to the smoking area and out the door entering the courtyard. Resident #1 explained he turned his wheelchair around, attempted to light a partially smoked cigarette and it caused the nasal cannula to spark a fire from the unused oxygen that remained in the tubing to light directly from the flame of the lighter which caused a flame and him to become burned. Resident #1 reported he immediately swatted at his nose causing his nasal cannula to fall to the ground. Resident #1 indicated he knocked the nasal cannula from his nostrils, but the damage was already caused by that point. Further interview with Resident #1 on 2/26/21 at 10:00 AM and 12:00 PM revealed Resident #1 acknowledged he was asked by Nurse #2 if he wanted to go to the emergency room and he declined due to his fear of not being allowed to smoke anymore; however, if he had realized how much discomfort the burn would cause he would have agreed immediately. An interview with Nurse #1 on 3/1/21 at 12:42 PM revealed she had been Resident #1's Nurse during day shift on the date of his accident. She reported she had just went off duty and was in the nurses station charting at the time NA #1 approached her and made her aware that Resident #1 had lit a cigarette with his oxygen in place and it had caught fire. Nurse #1 explained she instinctively got up and went to assess Resident #1 who had made it almost to his room when she arrived. Nurse #1 stated she noticed	F 580	changes in resident status related to incidents resulting in injury that has potential to require medical director intervention. All new hire certified nursing assistants and licensed nurses will be educated on notifying of changes. 4. A notification audit tool was implemented by director of nursing on 3/1/21 and will be discussed 5x weekly for 1 month and 1x weekly for 3 months during daily clinical meeting to ensure notification is completed as needed. QAPI meeting completed on 3/15/21 with medical director. Administrator, director of nursing, and interdisciplinary team will review findings and notification audits monthly for three months for follow-up and recommendations for continuation as needed. Compliance date of 3/6/21	

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the black soot on his face and immediately went to the treatment cart and collected items to clean his face and some burn cream because she knew it worked well for burns without calling the physician for orders. Nurse #1 said she returned to Resident #1's bedside and cleaned his face and applied the cream and then immediately went to notify the Administrator via telephone for further instructions. Nurse #1 did not ask the resident if he wanted to go to the hospital on the night of the accident as she had already turned over Resident #1's care to Nurse #2 and was only assisting with assessment because she was alerted by NA #1. Nurse #1 revealed she did not contact any medical provider that night and assumed Nurse #2 would alert the provider of the accident since she had turned the care over to Nurse #2.

An interview on 2/27/21 at 2:30 PM revealed Nurse #2 was assigned to Resident #1 at the time of the incident but had just come on shift and Nurse #1 had assessed and handled Resident #1's injuries and therefore she had not reassessed the injuries or notified the medical provider during her shift. Nurse #2 stated she was instructed to ask Resident #1 the following morning before ending her shift if he wished to go to the emergency room for evaluation and he had then declined but said it was still very uncomfortable. Nurse #2 explained Resident #1 frequently reported pain and therefore she had not clarified if Resident #1's discomfort was from his disease process or from the burn he sustained on 1/28/21.

An interview with the Administrator on 2/25/21 at 6:00 PM revealed she was aware that Resident #1 had lit himself on fire when he tried to light a

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cigarette while he had his oxygen tank. The Administrator stated she knew Resident #1 "singed" his nasal hair and under his eye but had refused to go to the hospital on the night the incident occurred so the Wound Doctor was contacted via telehealth by her the next day and the Wound Doctor ordered cream for under his eye and a nasal swab gel for his nose.

An interview with Wound Doctor on 2/26/21 at 10:30 AM revealed as best he could recall the burns sustained by Resident #1 on the night of 1/28/21 were second degree in severity but he was not consulted until 1/29/21 for a wound care evaluation of the burns which was provided via a tele health visit.

An interview with the Medical Director (MD) on 2/26/21 at 4:30 PM revealed he had been made aware of Resident #1's incident the following week when he arrived at the facility to make routine rounds for resident care needs. He explained he would have expected staff to have been contacted him or a member of his on-call staff immediately following the accident of a resident who had sustained burns from oxygen usage.

An interview with the Physician's Assistant (PA) on 3/1/21 at 3:30 PM revealed he was made aware of the burns sustained by Resident #1 when he entered Resident #1's room on 2/4/21 at the residents' request to review his medication. The PA indicated Resident #1 told him he had sustained burns to his face when he was smoking with his oxygen tank on his wheelchair and nasal cannula intact to his nostrils. The note written by the PA did not mention the current condition of Resident #1's skin on 2/4/21 but classified the

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F 580	Continued From page 13 burn to be superficial.	F 580		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview, and facility documents titled "Resident Smoking", the facility failed to provide a safe smoking environment for two smokers when staff failed to properly store oxygen at a safe distance from open flame and prevent a resident who utilized oxygen from smoking while his oxygen was in use for 2 of 2 residents reviewed for safe smoking (Resident #1 and Resident #2). Resident #1 lit a cigarette with his nasal cannula in his nares and his oxygen tank on while out in the designated smoking area which resulted in burns to the resident's face and high likelihood of injury to the other resident who was in the smoking area. The findings included: A review of the facility document titled "Resident Smoking" reviewed/revised 10/22/20 indicated on page 1 of 2 the facility provides a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and	F 689	Past noncompliance: no plan of correction required.	3/23/21

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non-smoking residents. It further indicated safety measures for the designated smoking area will include, but not limited to: "2e: prohibition of oxygen use in the smoking area. 5. All residents and family members will be notified of this policy during the admission process, and as needed. 6. Residents will be asked about tobacco use during the admission process, and during each quarterly and comprehensive minimum data set (MDS) assessment process. 7. Residents who smoke will be further assessed, using the Resident Safe Smoking Assessment, to see if any residents are safe to smoke at all. 8. Any resident who is deemed safe to smoke, WILL BE SUPERVISED, will be allowed to smoke in designated smoking areas (weather permitting), at designated smoking times, and in accordance with his/her care plan. 9. If a resident who smokes experiences a decline in condition or cognition, he/she will be reassessed for ability to smoke independently and/or evaluate whether any additional safety measures are indicated. 10. All safe smoking measures will be documented on each resident's care plan and communicated to all staff, visitors, and volunteers who will be responsible for supervising residents while smoking. Supervision will be provided as indicated on each resident's care plan. 12. If a resident or family member does not abide by the smoking policy or care plan (e.g. smoking materials are provided directly to the resident, smoking in non-smoking areas, does not wear protective gear), the plan of care may be revised to include additional measures such as room searches, prohibited smoking, or even discharge.

Resident #1 was admitted to the facility on 11/10/2020 with diagnoses that included acute and chronic respiratory failure with hypoxia,

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chronic obstructive pulmonary disease (COPD) and dependence on supplemental oxygen.

A physician's order dated 11/11/20 revealed Resident #1 was to have 4-5 liters (L) of continuous oxygen per nasal cannula to keep oxygen saturations above 90%.

According to signed admission agreement dated 11/10/20, Resident #1 did not sign a copy of the smoking policy on admission as Exhibit B in the agreement.

Resident #1's admission document titled "Safe Smoking Screen" dated 11/10/20 indicated the Resident was a current smoker, does not use supplemental oxygen and may smoke independently without supervision.

Resident #1's admission Minimum Data Set (MDS) dated 11/13/20 revealed Resident #1 required supervision to two person staff assist for transfers, was cognitively intact, and used oxygen while a resident.

A review of Resident #1's admission care plan dated 11/13/20 did not include a care area for smoking.

A care plan conference note dated 11/25/20 revealed Resident #1 participated in self-directed activities of smoking.

A physician's progress note written by the Medical Director (MD) dated 1/18/21 indicted Resident #1 was non-ambulatory, transfers to wheel chair, requires assistance with multiple activities of daily living (ADL), utilizes 5 liters (L) of oxygen via nasal cannula (NC), and smokes 1 pack of

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cigarettes per daily as current usage.

A nurses' progress note documented by Nurse #1 dated 1/28/21 revealed Resident #1 was smoking with his oxygen tank on the back of his wheelchair and his nasal cannula intact to his nostrils bilaterally which ignited a flame and caused Resident #1 to be burned on his upper lip, nose, left side of cheek, left eyelid, and left eyebrow.

Interview conducted on 2/25/21 at 5:55 PM with Resident #1 revealed he had suffered burns to his face following a smoking incident he was involved in approximately a month ago. Resident #1 reported he had been assessed as a safe smoker when he was admitted to the facility and had always gone outside with his oxygen tank on the back of his wheelchair on many occasions; however, this was the first time he had failed to remember to remove his nasal cannula from his nose and turn off his oxygen tank before lighting a cigarette. Resident #1 explained on the night of the accident, he had arrived at the smoking area shortly before the time for designated smoking time to end, felt rushed as he hurried and self-propelled his wheelchair past NA #1 who was standing in the doorway to the smoking area and out the door entering the courtyard. Resident #1 explained he turned his wheelchair around, attempted to light a partially smoked cigarette and it caused the nasal cannula to spark a fire from the unused oxygen that remained in the tubing to light directly from the flame of the lighter which caused a flame and him to become burned. Resident #1 reported he immediately swatted at his nose causing his nasal cannula to fall to the ground. Resident #1 indicated as he knocked the nasal cannula from his nostrils, Resident #2

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reached over and turned his oxygen tank to the off position. He stated he felt very rushed and singled out by NA #1 for being late that night to the smoking area and then when he finally arrived to the area, after already being winded from self-propulsion of his wheelchair down the hallway, he was rushing himself so much he strictly forgot to even remove the nasal cannula from his nostrils and turn off the oxygen. He indicated NA #1 didn't even say anything to him about being outside with the oxygen tank on his wheelchair before he lit the cigarette that night. Resident #1 expressed remorse for his actions and not thinking about the safety of himself and others and took partial blame for his injuries. Resident #1 indicated after the fire was extinguished, NA #1 left him and Resident #2 outside in the smoking area and went inside the building leaving the oxygen tank on the back of his wheelchair. Resident #1 smoked his other cigarette before returning to his room.

Further interview with Resident #1 on 2/26/21 at 10:00 AM and 12:00 PM revealed Resident #1 was not able to self- propel himself down the hall without oxygen usage or place his oxygen tank in the tank holder located to the right of the door to the smoking area. Resident #1 further elaborated staff had seen him outside before with his tank on the back of the wheelchair and had made no attempts to remove it or check to see if it had been turned off prior to this incident. Resident #1 stated prior to this accident, he had gone outside anytime he wanted independently to smoke. Resident #1 acknowledged he was asked by Nurse #2 if he wanted to go to the emergency room and he declined due to his fear of not being allowed to smoke anymore; however, if he had realized how much discomfort the burn would

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cause he would have agreed immediately.

Resident #2 was admitted to the facility on 01/11/21.

A review of the admission Minimum Data Set (MDS) dated 01/18/21 revealed Resident #2 to be cognitively intact.

Interviews conducted on 2/25/21 at 5:00 PM with Resident #2 revealed Resident #1 had recently had an accident with smoking while wearing oxygen and it had caused him to receive burns to his face and all smoking residents to have their privileges altered. Resident #2 further reported he was in the smoking area on the night of Resident #1's smoking incident and had witnessed and assisted in extinguishing the fire. Resident #2 explained at around the time of the facility's last smoking time in the evening, between 8:00-8:30 PM, but could not recall the exact date but believed it to be about 3 weeks ago, he witnessed NA #1 shaking her keys at Resident #1 and telling him to hurry up and smoke or she wasn't going to let him have a smoke break that night because she was locking the doors. Resident #2 revealed he witnessed Resident #1 roll out the door towards him, turn around and park his wheelchair directly next to him, and start to light up a cigarette when all of a sudden he saw a big spark and saw the flame on Resident #1's face. Resident #2 accounts witnessing Resident #1 immediately reach up to remove the nasal cannula which remained in his nostrils and throw it down to the ground and try to reach around to turn off the oxygen tank. Resident #2 quickly reached over and turned it off before NA #1 could reach Resident #1. Resident #2 explained NA #1 checked to make sure the tank had been turned

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off and Resident #1 was no longer burning and then, turned and went inside the building leaving the oxygen tank on the back of the wheel chair of Resident #1.

Further interview of Resident #2 on 2/26/21 at 10:20 AM revealed Resident #1 had proceeded to smoke his additional cigarette with no staff present before entering back into the building after he had already sustained a burn to his face. Resident #2 stated, I told him (Resident #1) "her (NA #1) rushing you like she was dangling the keys at you and you not turning off your tank, you could have killed us all doing stuff like that. You really need to be more careful next time". Resident #2 revealed he did not get injured during this incident; however, his privileges had been altered along with the other smokers as a result of the incident with Resident #1. Resident #2 verbalized he had witnessed Resident #1 with the oxygen tank on the back of his wheelchair in the past, but Resident #1 had not previously been witnessed to have his nasal cannula intact prior to the accident.

An interview with NA #1 on 2/25/21 at 7:30 PM revealed she was on light duty on the night of 1/28/21 and was assigned to lock the smoking area after the last smoke break. NA #1 explained she told Resident #1 and Resident #2 it was "time to wrap it up and come back inside because she had to lock the door." NA #1 stated Resident #1 and Resident #2 were the only residents in the smoking area of the courtyard when the incident occurred. NA #1 confirmed she was present at the door when Resident #1 exited the building and had told him he must hurry, or he would not be allowed to smoke anymore that evening. She further revealed as Resident #1 propelled his

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wheelchair past her, there was a conflict of what time the door was to be locked and stated it was about 8:15 PM at the time and the residents had indicated the smoke time was to last until 8:30 PM according to the Administrator and didn't even notice the oxygen tank on the back of Resident #1's chair or that Resident #1 had the nasal cannula in place. NA #1 stated the next thing she knew, Resident #1 lit a cigarette. She heard it whistle and had seen the flash and about that time Resident #1 hit his face and extinguished the fire and put it out knocking the nasal cannula from his nose to the ground. NA #1 went over to him to make sure he was not on fire and checked his oxygen tank and it was on so, she turned it off and made sure Resident #1 and Resident #2 were okay and they were fine other than the charring that Resident #1 had to his face. The flame had charred Resident #1's nose and the left side of his face from his eyebrow down to the top of his beard. NA #1 revealed she went in the facility and told Nurse #1. NA #1 reported she did not think about removing the tank from the wheelchair after the accident nor securing his other cigarette and lighter and bringing him back in before alerting Nurse #1 of the accident. NA #1 explained Resident #1 should have removed his oxygen tank from the wheelchair before entering the smoking area and placed it in the canister holder in the day room. NA #1 admitted she had witnessed Resident #1 outside in the smoking area with his oxygen tank on the back of his wheelchair before and no one had ever said anything to Resident #1 but she had never noticed him having the nasal cannula still on his face when she had seen him in the past so most of the time she did not bother to go outside to remove the tank or ensure it was in the off position, but on the occasions she had checked

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the oxygen tank, it was in the off position. NA #1 elaborated prior to the accident, the routine for the smokers should be for them to remove their tanks from their wheelchair and place it in the oxygen holder inside the dayroom adjacent to the smoking area.

An interview with Nurse #1 on 3/1/21 at 12:42 PM revealed she had been Resident #1's nurse during day shift on the date of his accident. She reported she had just come off duty and was in the nurses station charting at the time NA #1 approached her to make her aware Resident #1 had lit a cigarette with his oxygen in place and it had caught fire. Nurse #1 explained she instinctively got up and went to assess Resident #1 who had made it almost to his room when she arrived. Nurse #1 stated she noticed the black soot on his face and immediately went to the treatment cart and collected items to clean his face and some burn cream because she knew it worked well for burns without calling the physician for orders. Nurse #1 said she returned to Resident #1's bedside and cleaned his face and applied the cream and then immediately went to notify the Administrator via telephone for further instructions. Nurse #1 did not ask the resident if he wanted to go to the hospital on the night of the accident as she had already turned over Resident #1's care to Nurse #2 and was only assisting with assessment because she was alerted by NA #1. She was instructed to complete an incident report and make a note and the Administrator would further handle it when she arrived in the morning. Nurse #1 revealed she did not contact any medical provider that night and assumed Nurse #2 would alert the provider of the accident since she had turned the care over to Nurse #2.

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An interview on 2/27/21 at 2:30 PM revealed Nurse #2 was assigned to Resident #1 at the time of the incident but had just come on shift and Nurse #1 had assessed and handled Resident #1's injuries and therefore she had not reassessed the injuries during her shift. Nurse #2 stated she was instructed to ask Resident #1 the following morning before ending her shift if he wished to go to the emergency room for evaluation and he had then declined but said it was still very uncomfortable. Nurse #2 explained Resident #1 frequently reported pain and therefore she had not clarified if Resident #1's discomfort was from his disease process or from the burn he sustained on 1/28/21. Nurse #2 indicated she had never gone to the smoking areas to assess Resident #1 herself but did not feel like he was capable of safely removing his oxygen tank from the bag on the back of his wheelchair before exiting the facility to the smoking area. Nurse #2 further stated she had never gone out to the smoking area and was unsure whether he had been outside in the smoking area with his oxygen tank in place prior to 1/28/21.

An interview with the Administrator on 2/25/21 at 6:00 PM revealed she was aware that Resident #1 had lit himself on fire when he tried to light a cigarette while he had his oxygen tank. The Administrator stated she knew Resident #1 "singed" his nasal hair and under his eye but had refused to go to the hospital on the night the incident occurred so Wound Doctor (WD) was contacted via telehealth by her the next day and the WD ordered cream for under his eye and a nasal swab gel for his nose. The Administrator explained all residents were re-evaluated for safe smoking after that. The Administrator stated she

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interviewed the Nurse #1 and NA #1 assigned to Resident #1 following the incident and she asked, "the why's." The Administrator explained she and the Interdisciplinary Team (IDT) met the following week on 2/4/21 and decided to remove all the keys used to access personal smoking materials from individual residents possession and secure all items in a locker, limit smoking to an assigned schedule, and make all smoking times supervised. The Administrator also indicated all smokers had been reassessed for smoking, each provided a smoking apron, and been required to sign a copy of the smoking policy following the meeting as a corrective action. The Administrator explained she had not made any official monitoring protocols other than just to have the smoking supervised by a schedule and with a staff member present. She indicated she had not yet had a quality assurance meeting as they are provided monthly but did call the medical director and let him know what plan she and the IDT had put into place.

A follow-up interview with the Administrator revealed she had been made aware of the incident by Nurse #1 and had re-educated NA #1 on safe smoking practices. The Administrator revealed the following morning she contacted WD via telehealth visit who assessed Resident #1 and provided orders for the injury. In addition, the morning of 01/29/21 all staff were in-serviced, and an IDT meeting was conducted. The Administrator revealed the Root Cause Analysis (RCA) from the investigation was NA #1 was not being observant and had not noticed the resident had the oxygen on his wheelchair or the oxygen tubing in his nose. The Administrator revealed a combination of things caused the accident to include a small amount of oxygen that remained

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ACCORDIUS HEALTH AT WILKESBORO	1000 COLLEGE STREET WILKESBORO, NC 28697

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in the nasal cannula was ultimately what ignited the flame. However, she further elaborated when he lit a partially smoked cigarette, the remainder being too close to the nasal cannula, Resident #1 rushing because he wanted to quickly smoke his cigarette before the courtyard closed and the open flame from the lighter quickly flash sparked causing the burns to Resident #1's face. The Administrator noted Resident #1, in his rush, didn't realize he still had his oxygen on. She revealed Resident #1 was alert and oriented and knew his oxygen tank wasn't supposed be outside in the smoking courtyard because he doesn't have a cognitive deficit. The Administrator revealed when she talked to him after it happened, he voiced understanding but she stated Resident #1 had not voiced concern that his room was too far away from the smoke area at that time, but complained he was late to the smoke time. The Administrator revealed she completed the investigation and RCA; her expectation was that the aide should have noticed that Resident #1 had his oxygen on. The Administrator indicated she was unsure if anyone had assessed his ability to independently remove his oxygen tank from his wheelchair but would think the nurse who completed his smoking assessment would have done so. The Administrator explained prior to the accident and in the few months she had been there, there had been an oxygen tank holder placed in the doorway immediately prior to exiting from the facility into the designated smoking area and staff were aware oxygen was to be placed in this location prior to entering the smoking area and she felt the staff should have been aware of the importance of oxygen tanks not being in the vicinity of open flames due to the potential for fire.

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An interview with Wound Doctor stated as best he could recall the burns sustained by Resident #1 on the night of 1/28/21 were second degree in severity. There was not a documented note for this visit or the visit the following week.

An interview with the Medical Director (MD) on 2/26/21 at 4:30 PM revealed he had been made aware of Resident #1's incident the following week when he arrived at the facility to make routine rounds for resident care needs. The MD indicated he thought Resident #1 had been non-weight bearing at one time and was not certain Resident #1 had the physical ability to safely remove his oxygen tank from his wheelchair independently before exiting the facility to smoke and felt he would need staff assistance for this task. The MD also explained he had been made aware of the changes the IDT had planned to ensure safety during smoking but could not recall a date he was notified.

An interview with the Physician's Assistant (PA) on 3/1/21 at 3:30 PM revealed he was made aware of the burns sustained by Resident #1 when he entered Resident #1's room on 2/4/21 at the residents' request to review his medication. The PA indicated Resident #1 told him he had sustained burns to his face when he was smoking with his oxygen tank on his wheelchair and nasal cannula intact to his nostrils. The note written by the PA did not mention the current condition of Resident #1's skin on 2/4/21 but classified the burn to be superficial.

The Administrator provided the following corrective action plan with a compliance date of 02/05/21.

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On 1/28/21, Resident #1 entered the smoking courtyard with his oxygen tank attached to his wheelchair wearing his nasal cannula and lit a cigarette. This caused a flash burn to nares/lips and facial areas. Resident immediately extinguished the flame by dropping his nasal cannula to the ground. There was a Nursing Assistant (NA #1) in the courtyard at this time and assured flame was out, oxygen off. NA #1 stated that she did not initially notice the oxygen in place due to the resident customarily removes his own oxygen and places it in the tank holder prior to going outside. NA #1 left Resident #1 out in the courtyard with his oxygen tank attached but the Nasal Cannula had been removed and Oxygen turned off. She did so as was in a hurry to notify a nurse. Resident #1 and Resident #2 continued to smoke as if nothing had happened.

Nurse #1 was notified of incident by NA #1 and she went to assess for any injury and cleansed face and applied cream. Resident #1 did not indicate discomfort or any request for ER or further treatment. Nurse #1 reported off to Nurse #2. Nurse #2 checked on Resident #1 during her shift and he did not express any discomfort and declined her offer to go to ER or further treatment. On 1/29/21 the Administrator initiated a Telehealth visit with the Wound Doctor who prescribed Silver Sulfadiazine Cream. On 2/4/21 the Physician Assistant assessed Resident #1 and agreed with current treatment and noted superficial burns to face. The Physician Assistant discussed with Resident that he had removed oxygen for months prior to this incident and reinforced importance of removing prior to smoking.

Resident #1 has demonstrated his ability to

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perform the act of removing oxygen tank/nasal cannula without difficulty multiple times in the last three months prior to this incident and has not had any concerns. On 1/29/21 the Administrator had Resident #1 demonstrate ability to remove oxygen tank and nasal cannula and he did so without difficulty and voiced he has had no issues with this in the past. Resident #1 has a Brief Interview of Mental Status (BIMS) of a 15 on a scale of 0-15 being the highest level of cognition function measurable on this scale and had repeatedly shown ability and awareness to remove his oxygen tank and place in holder as well as remove his nasal cannula. Administrator interviewed Resident #1 on 1/29/21 whom indicated he had been compliant with removing oxygen tank and nasal cannula in the past, but this time felt rushed by the nursing assistant.

A Smoking Assessment of nine Residents was completed on 2/5/21 by the Assistant Director of Nursing. Eight of the nine were assessed at having the ability to smoke independently. Resident #1 was assessed for having the ability to smoke independently, however under the History part of his assessment it does indicate if any history of burning self then at minimum is a supervised smoker.

Administrator interviewed Resident #2 on 1/29/21 and he reported that he was in the smoking area at the time of the incident and he was not harmed and felt the nursing assistant was rushing both Residents to finish smoking. Resident #2 has a Brief Interview of Mental Status (BIMS) of a 15 on a scale of 0-15 with 15 being the highest level of cognition function.

Administrator was in contact immediately after the

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incident, assured safety of Resident #1 and Resident #2. Had all the smoking materials (lighters) gathered and locked up until she could meet with Smokers and assure a safe plan. Administrator will continue to honor Resident preferences and meet with Residents as needed.

Administrator re- educated the nurse aide #1 on 1/28/21 on the safety factors around smoking and that at no time can an oxygen tank or cannula be present on a resident while smoking. She was also re-educated on validating that any oxygen tank that was removed from or by the resident was secured in the rack prior to going to the smoking area. In addition, she was educated on importance of customer service related to not rushing Residents.

Resident #1 has a Brief interview mental status of a 15 and can articulate that he cannot have his oxygen or cannula in place while smoking. He can remove the cannula and tank prior to smoking and the person supervising smoking will now ensure that no resident has an oxygen tank or cannula in place while smoking. Resident #1 continues to show ability of removing tank/nasal cannula.

On 1/29/21 the Administrator reviewed Smoking Policy and Procedure with Residents that smoke, and Residents signed policy. Residents were in agreement regarding safety and supervision and reviewed the procedure for location of oxygen tank in canister holder with nasal cannula and no oxygen in smoking area.

On 1/29/21 the Administrator educated all Department Heads and Smoking Attendants (staff that assist with Residents that smoke), regarding

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smoking policy and location for oxygen tanks. The Administrator educated on importance of no oxygen in the smoking area, the location for oxygen tanks / cannulas and importance to assure Resident #1 can still safely remove his own tank and if not, then staff is to assist. This education will be part of orientation as well for new hires which the Administrator notified Human Resources and Assistant Director of Nursing on 1/29/21.

On 1/29/21 the Administrator assured appropriate and very visible signage regarding smoking area and no Oxygen in the area.

On 1/29/21 the Administrator implemented and educated on a monitoring tool for Smoking Attendants to assess all Residents during smoking regarding appropriate Protective Gear(Apron)/Smoking Materials and Oxygen secured in Canister. The Smoking Attendants are to initial each shift regarding assurance of appropriate Protective Gear (Apron)/Smoking Materials and Oxygen secured in canister. This tool will be utilized for 3 months with findings reported to Monthly QAPI and ongoing as needed. Administrator and Department Head Designee will assure continued compliance with random observations of smoking area and report during monthly QAPI.

On 1/29/21 the Administrator held an AD HOC QAPI with Department Heads in attendance regarding Safety with Smoking and continuous monitoring. The facility will continue to monitor safety with smoking for three months with findings reported to Monthly QAPI for three months and ongoing as needed.

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On 03/05/21 the facility's corrective action plan with a correction date of 02/05/21 was validated by the following:

A review of the facility's inservice attendance sheets and facility records indicated, NA #1 was re-educated on oxygen safety for the resident who smoked, the Administrator reviewed the Smoking Policy and Procedures with the residents who smoked and had the residents sign the policy and the Administrator educated all Department Managers and Smoking Attendants on the Smoking Policy and Procedure.

Interviews were conducted with the residents identified as smokers both safe and unsafe. The smokers were able to explain the new smoking policy that included being allowed to smoke at will and when ever they desired if they were deemed a safe smoker but if a resident was deemed a supervised smoker, they had to abide by the allotted times to smoke. The residents explained the procedure of putting the oxygen tanks in the oxygen holder before they went out to smoke if they required oxygen and the need to social distance during their smoking session. All the residents accepted the new smoking policy.

Observations were made of the "No Oxygen" sign posted at the smoking area entrance and an oxygen tank holder adjacent to the wall near the smoking entrance. The smoking area had spaces marked with an "X" that were spaced 6 feet apart to indicate the social distancing plan. The residents were observed to abide by the social distancing plan and there was a Smoking Attendant monitoring the residents.

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F 689	Continued From page 31 Interviews were conducted with Smoking Attendants who explained that they had to complete a monitoring tool during each smoking session to indicate if the residents wore a smoking apron and if a resident used oxygen the tank was stored in the canister inside the facility. Interviews were conducted with the Department Managers who explained they had to monitor the smoking area for compliance of the new smoking policy at designated and assigned times. The monitoring tools was reviewed and verified at the time of the interview. Review of the inservice training records included current staff from all the departments and the Department Managers were educated on the new Smoking Policy and Procedures. An interview was conducted with the Administrator who explained that she had a meeting with all the resident smokers and explained the new Smoking Policy and Procedures. She stated she had a general inservice with all the staff including the Department Managers on 01/29/21 and introduced the new Smoking Policy and Procedure and the monitoring tool which was initiated because of the smoking incident. The Administrator stated the monitoring tools will be reviewed in the monthly QA meetings for 3 months and longer if needed.	F 689		
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must-	F 711		3/6/21

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F 711	Continued From page 32 §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and medical provider interviews, the facility failed to obtain a physician's progress note for one resident who received a wound evaluation for an acute facial burn when services were consulted of a wound care physician via a tele health visit and a follow-up progress note when a resident was seen in person by this provider for 1 of 1 residents reviewed for physician's progress notes (Resident #1). Findings included: A nurses' progress note documented by Nurse #1 dated 1/28/21 revealed Resident #1 was smoking with his oxygen tank on the back of his wheelchair and his nasal cannula intact to his nostrils bilaterally which ignited a flame and caused Resident #1 to be burned on his upper lip, nose, left side of cheek, left eyelid, and left eyebrow. An interview with the Administrator on 2/25/21 at 6:00 PM revealed she was aware that Resident	F 711	F711- Physician Visits- Review Care/Notes/Order 1. A root cause analysis was performed on 2/25/21 and completed on 3/4/21 in regard to the facility□s failure to ensure a physician visit progress note/order was completed following the wound care physician□s evaluation on resident #1 on 1/29/21. The root cause analysis determination was led by the administrator with input from Director of Nursing, Assistant Director of Nursing/ Infection Preventionist, Unit managers, Activity Director, Social Worker, Therapy director, Maintenance director, and Admissions director. The results of the root cause analysis were reviewed by administrator and wound care physician on 3/4/21 and incorporated into the facility□s plan of correction. Education provided by administrator to wound care physician regarding the physician visit requirements on 3/3/21. Wound physician updated his progress note on 3/3/21.	

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F 711	Continued From page 33 #1 had lit himself on fire when he tried to light a cigarette while he had his oxygen tank. The Administrator stated she knew Resident #1 "singed" his nasal hair and under his eye but had refused to go to the hospital on the night the incident occurred so Wound Doctor (WD) was contacted via telehealth by her the next day and the Wound Doctor ordered cream for under his eye and a nasal swab gel for his nose. An interview with Wound Doctor on 2/26/21 at 10:30 AM revealed as best he could recall the burns sustained by Resident #1 on the night of 1/28/21 were second degree in severity but he was not consulted until 1/29/21 by the facility Administrator for a wound care evaluation of the burns which was provided via a tele health visit. There was not a documented note for this visit or the visit the following week. The Wound Doctor indicated he had not provided a physician progress note because he was only consulted for evaluation and did not pick up the resident for ongoing care of the burns. An interview with the Medical Director (MD) on 2/26/21 at 4:30 PM revealed had he been made aware of the burns sustained by Resident #1 immediately, he would have assessed the areas, provided a treatment regimen for his medical care, and provided a progress note for the medical record. An interview with the Physician's Assistant (PA) on 3/1/21 at 3:30 PM revealed if he was made aware of the burns sustained by Resident #1 prior to his arrival at the facility on 2/4/21 at the residents' request to review his medication, he would have evaluated Resident #1's facial burns and provided orders to address his plan of care.	F 711	2. All residents have the potential to be affected therefore audited the previous two weeks of physician visits to ensure completion and ensure regulatory compliance in regard to physician visits. 3. Wound care physician, Medical director, Physician Assistant, wound care nurse, unit managers, MDS coordinator, and Director of nursing were educated on the physician visit regulatory compliance and the importance of ensuring completion of reviewing care/notes/orders following all physician visits by administrator on 3/1/21. Newly hired clinical management will be educated on the physician visit regulation. 4. Administrator will meet with Medical director, PA, and wound doctor weekly to review records for completion for four weeks starting 3/4/21 then monthly for three months to ensure continued compliance. Interdisciplinary team will review findings for follow-up and recommendations for continuation as needed. Any adverse findings will be addressed immediately and educated. Compliance date of 3/6/2021	

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F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		3/6/21

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F 880	Continued From page 35 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview, the facility failed to follow guidance produced by the Centers for Disease Control and Prevention by socially distancing 8 residents observed smoking in the courtyard adjacent to the facility for 8 of 8 residents reviewed for infection control (Resident #1,#2,#3,#4, #5, #6, #8, #9) . Findings included:	F 880	F880 Infection Prevention and Control 1. A root cause analysis was conducted on 2/25/21 and completed on 3/1/21 to identify the root cause of the facility□s failure to ensure residents were socially distanced in the smoking area per the 8 out of 8 residents reviewed for infection control practices. These infection control failures occurred during a global COVID-19 pandemic. The root cause analysis determination was led by the	

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F 880	Continued From page 36 According to the CDC guidelines titled "Additional Strategies Depending on the Facility's reopening status" dated 11/20/20 indicated facilities must implement "aggressive social distancing measures (remaining at least 6 feet apart from others)." Facility Infection Control policy review dated 03/04/20 and ongoing revealed any resident showing any signs of respiratory illness may not participate in outdoor activities. It further indicated residents who smoke should maintain a minimum distance of 6 feet, but further distance is preferred. An observation was made on 2/25/21 beginning at 7:30 PM and ending at 8:00 PM revealed 8 residents and 1 staff member (Patient Care Aide-PCA #1) seated in the designated smoking area smoking and socializing. Seven of the 8 residents were seated in their wheelchairs and one resident (Resident #8) was ambulating in the area then, he was observed to sit on a bench next to Resident #5. Three gentlemen (Resident #1, Resident #2, and Resident #9) were positioned on the right side of the courtyard approximately 18 inches apart and in line with a pole support for the awning. Approximately 3 feet directly in front of the gentlemen were 3 ladies (Resident # 3, Resident #4, and Resident #5) seated side by side surrounding a black smoking disposal receptacle with the wheelchairs touching in a line. Resident #6 was seated in his wheelchair at the left side of the picnic bench across from PCA #1. Eight of the 8 residents were observed to enter the smoking area wearing face coverings; however, all residents removed their face coverings to smoke and were not seated the recommended distance of 6 feet apart to maintain	F 880	administrator with input from Director of Nursing, Assistant Director of Nursing/ Infection Preventionist, Unit managers, Activity Director, Social Worker, Therapy director, Maintenance director, and Admissions director. The results of the root cause analysis were reviewed by QAPI committee on 3/1/21 and incorporated into the facility□s plan of correction. All residents were immediately educated by administrator on 2/26/21 on the proper space that must ensure safe infection control social distancing requirements. The residents were also educated on all infection control requirements in the smoking area such as wearing a mask before and after smoking for infection control purposes. 2. All in-house smokers have the potential to be affected, therefore were evaluated on 2/26/21 to include 2 additional residents, to ensure knowledge and compliance with procedures and following the social distancing requirements of infection control. The residents were also educated to choose a designated place in the smoking area that is labeled on the ground for social distancing. In addition to already placed signage around the facility, the administrator added additional signage on 2/26/21 for ease of observation for staff and residents indicating social distancing requirements to ensure compliance with infection control practices. 3. Staff were educated beginning on	

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	345133	A. BUILDING _____ B. WING _____	C 03/05/2021

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F 880	Continued From page 37 a safe social distancing practice. An additional observation was made on 2/26/21 at 10:30 AM revealed 7 residents in the smoking courtyard with PCA #2. Residents #1, #2, and #9 were appropriately distanced during this observation; however, Resident's #3 and Resident #4 were observed again seated facing the black smoking disposal receptacle as observed on 02/25/21 with their wheelchairs touching. Resident #8 was observed to be ambulating throughout the entire smoking area socializing and lighting other resident's cigarettes. Resident #8 was not observed to be wearing a mask when interacting with the resident's he lit their cigarettes (Resident #3 and Resident #4). Resident #9 was observed to again be seated to the left end of the picnic bench across from PCA#2. An interview with PCA #1 on 2/25/21 at 8:30 PM revealed he had only been employed at the facility a month. He stated 8 residents were seated in the smoking area without masks and according to a hand drawn diagram of seat placement were not socially distanced of 6 feet apart. An interview with PCA #2 on 2/26/21 at 10:45 AM revealed 8 residents were seated in the smoking area without masks smoking cigarettes and were not seated in a placement that provided a social distance environment of 6 feet apart. An interview with the Administrator on 3/4/21 at 3:45 PM revealed she was aware 8 residents were observed in the designated smoking courtyard on both 2/25/21 and 2/26/21. She was not aware residents were not placed in a socially	F 880	2/25/21 and completed on 3/5/21 by the Director of Nursing on infection control practices to include social distancing in the smoking area, as well as continual monitoring of residents to ensure compliance. Any adverse event will be immediately addressed and educated immediately by Administrator, Director of Nursing, or department head. Additional infection control training and social distancing requirements in smoking area will be in-serviced to all new hires. 4. Infection control audits regarding infection control and social distancing will be completed daily by Personal Care Assistant (PCA) for 30 days starting 2/26/21 and reviewed daily by assigned department head for 30 days starting on 2/26/21, then 1x weekly for 4 weeks to ensure proper infection control practices and social distancing are followed appropriately. This audit will be documented on the infection control monitoring tool. Any adverse findings will be addressed immediately, and education will be provided. The administrator will review findings of the infection control audit tool with the interdisciplinary team monthly for three months for follow-up and recommendations for continuation as indicated to ensure the specific deficiency cited remains corrected and in compliance with the regulatory requirement. Compliance date of 3/6/2021	

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F 880	Continued From page 38 distanced environment. The Administrator stated residents are always to be placed 6 feet apart when in the smoking area and indicated they are supposed to be seated over the "X" areas labeled on the ground. She indicated PCA #1 and PCA #2 should ensure residents were placed on these designated spots to prevent exposure to infection and felt both PCAs understood the importance of socially distancing to prevent the spread of COVID-19 during a global pandemic.	F 880		