| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 035135 | A. Building<br>B. Wing | 05/20/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Montecito Post Acute Care and Rehabilitation | 51 South 48th Street<br>Mesa, AZ 85206 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51158<br><br>Based on record review, observations of practice, staff and representative interviews the facility failed to ensure adequate supervision for 1 of 2 sampled residents (#39) while smoking. The deficient practice resulted in the resident sustaining life-threatening injuries.<br><br>Findings include:<br><br>Resident #39 was admitted originally on March 3, 2014 and readmitted on [DATE] with diagnoses that include hemiplegia and hemiparesis, peripheral vascular disease, dementia, long QT syndrome, cognitive communication disorder, anemia and major depressive disorder.<br><br>Review of resident #39 's clinical record revealed a smoking policy/consent dated December 6, 2018 with the resident ' s signature.<br><br>Review of the resident ' s clinical record revealed a care plan focus of ' potential for injury related to smoking ' created on August 25, 2014 and last revised September 12, 2022. The goal was that the resident will have no injuries related to smoking and will be compliant with smoking protocols and individual smoking plan until the next review. The interventions included: complete smoking assessment, explain the smoking policy, maintain smoking materials at nurses ' station or other designated area and monitor to assess compliance with facility smoking policy/individual plan.<br><br>Review of the resident annual Minimum Data Set (MDS) dated [DATE] indicated the resident had a Brief Interview for Mental Status (BIMS) summary score of 15 indicating the resident was cognitively intact.<br><br>A progress note created by a Licensed Practical Nurse (LPN/staff #97) dated May 17, 2025 at 18:0 revealed that a call for assistance was paged on the facility ' s radio system for staff to come to the smoking patio for patient assistance. The patient was alert and oriented but complaining of discomfort to his face and left side of his body. The patient stated that he was smoking his cigarette unsupervised. The patient was noted to have redness on his neck and left side of his face. The provider was notified and ordered for the resident to be sent out 911. The resident was taken to the local burn center at roughly 17:30.<br><br>A progress note created by the Assistant Director of Nursing (ADON/staff #67) dated May 18, 2025 at 8:24 a. m. indicated that the resident ' s emergency contact was informed of the incident.<br><br>(continued on next page) |

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

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

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | An order was created by the Primary Care Physician (PCP) on May 17, 2025 at 17:40 to send the resident to the burn center for further evaluation via 911.<br><br>An interview was conducted with an LPN (staff# 83) on May 20, 2025 at 12:12 p.m., the staff member stated that the facility ' s process is to assess residents on admission to ensure that residents who would like to smoke can do so safely. The LPN stated that the staff should hold all smoking paraphernalia (i.e. cigarettes, lighters, matches and/or electronic cigarettes). Staff #83 said that the online assessment that is done quarterly helps identify needs that residents might need while smoking like aprons. The LPN confirmed that she had heard about the smoking accident that occurred that weekend but declined to tell specifics as she was not working at that time and had only heard of what transpired.<br><br>An interview was conducted with an ADON (staff# 67) on May 20, 2025 at 1:06 p.m., the staff member stated that the facility ' s process is to gain consent and assess the resident on admission to ensure that the resident can safely smoke. The ADON stated that there is a smoking cart on a unit that keeps all the smoking paraphernalia for residents. Staff #67 stated that the day of the incident she was called in by the floor nurses. She further stated that she predominantly made notifications to the provider and the family. The ADON stated that she was told a staff member was walking by the smoking patio and noticed the resident was on fire and called for help. She further stated that the resident was on the patio without staff supervision and it was not a designated smoke break. Staff # 67 stated that the resident ' s blanket had burned and he had redness on his face and neck. The ADON also stated that the resident was deemed safe to smoke with an apron and supervision as his quarterly assessment had just been completed. The ADON identified risks of no supervision while the resident was smoking would be burns and that smoking materials could be shared with residents who should not have access to them.<br><br>An interview was conducted with a Certified Nursing Assistant (CNA/staff# 73) on May 20, 2025 at 1:14 p.m., the CNA stated that she is only responsible for taking the residents to the smoking patios and another department will supervise the smoke break.Staff #73 stated that the smoking cart is locked and the key is at the nurses station. She further stated that the only information that she had regarding the incident over the weekend was that he went alone and caught on fire.<br><br>An interview was attempted with the resident ' s emergency contact on May 20, 2025 at 11:26 p.m.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | An interview was conducted with the Director of Nursing (DON/staff# 59) on May 20, 2025 at 1:30 p.m., the staff member stated that the facility ' s process is on admission to identify residents who want to smoke. The DON stated that a staff member will have the resident sign the consent/policy form and let them know that residents are not allowed to keep smoking materials on their person. Staff #59 also stated that residents are reevaluated quarterly in addition to if there is a change in condition in order to ensure the resident is still safe to smoke. A request was made for resident #39 ' s most recent smoking assessment and it was not provided. The DON stated that smoking materials are to be maintained and kept by the staff on a medication cart on a downstairs unit, and the key is located at the nurses station. She further stated that supervisory staff is on a rotating block with different departments. The DON stated that on Saturday May 17, 2025 she received a call that a resident was being sent to the hospital because of an incident he had with smoking. She was told that a CNA said she was passing by the smoking patio towards the kitchen and noticed that the resident ' s blanket (that was on his lap) was on fire. The CNA called for help and attempted to put the fire out. The DON stated that it was reported to her that resident #39 ' s beard was singed and redness was noted but she could not confirm if the resident himself was on fire. The resident did not initially want to be transferred, he just wanted to go to bed but staff convinced him to go. Staff #59 stated that the smoking patio was then locked at all times unless it was an appointed smoke break with staff present to supervise. The DON identified risks of unsupervised smoking would mainly be surrounding safety and the potential for injury is higher.<br><br>An interview was conducted with the resident's family member/emergency contact on May 21, 2025 at 4:29 p. m. The residents representative stated that the resident was currently in and out of consciousness at the burn center. The resident ' s representative stated that the burn provider informed her that the resident suffered 3rd degree burns and was awaiting swelling to minimize to see if he needed a skin graft to the affected area. The resident ' s family member further stated that the facility notified her of the incident and she was told that it was his beard that initially caught on fire and it spread down to his lap. She further stated that she would not know how the resident obtained the smoking materials, he has no family other than her husband and herself and they lived in a different state.<br><br>Review of facility policy titled, Smoking policy/E-cigarettes, stated that it is the policy of this facility to provide those residents who choose to smoke a means in which to do so that does not jeopardize their safety or the safety of others residing in the facility. The policy noted that no lighting materials (e.g. matches, lighters) , tobacco products, smoking devices or e-cigarette devices will be allowed to be kept in the possession of the residents, either on their person or in the room. The policy also stated that the frequency of smoking for all residents will be the following times with staff supervision: 9:15 AM, 1:15PM, 4 PM, 7PM, 8:30PM. These times will be no more than 15 minute increments. |