STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035277	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Lakeside	3401 North Lockwood Drive Lakeside, AZ 85929

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 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical review, interviews and facility policy review, the facility failed to ensure that two residents (#75 and #10) were free from injuries from a preventable accident. The deficient practice could lead to serious injury or death to residents. Findings include: - Regarding resident #10: Resident #10 was admitted to the facility on [DATE] with diagnoses of myocardial infarction type 2, acute respiratory failure with hypoxia, chronic obstructive pulmonary disease with acute exacerbation, psychotic disorder with hallucinations due to known physiological condition, bipolar disorder current episode with hypomanic, burn of third degree of abdominal wall, burn of second degree of abdominal wall, dependence on supplemental oxygen, depression and anxiety disorder. Review of a smoking policy signed by the resident dated [DATE] revealed that the policy indicated that smoking is prohibited in any area where oxygen is being administered or stored. The policy indicated acknowledgement by the resident that the policy was reviewed and that violations may result in forfeiture of smoking privileges. A smoking care plan initiated on [DATE] indicated a goal of smoke safety at designated areas at scheduled times. Interventions included orientation to smoking procedures and areas, and smoking policy provided to resident/resident representative. Review of the smoking evaluations dated [DATE], [DATE], and [DATE] revealed that resident #10 did not have cognitive loss, no visual deficit and no dexterity problems. Frequency was 2-5 cigarettes per day and preferred to smoke mornings, afternoons, evenings and at night. He was considered a safe smoker due to he could light his own cigarette and did not require any adaptive equipment such as: a smoking apron, cigarette holder, supervision or one to one assistance. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed resident #10 had a BIMS (Brief Interview for Mental Status) score of 15, indicating no cognitive impairment. (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 Level of Harm - Actual harm Residents Affected - Few	A progress note dated [DATE] documented that at approximately 5:00 PM, resident #10 was outside smoking when he dropped his cigarette causing his oxygen tank, clothes right flank, stomach, and upper thigh to catch fire. According to the note the resident ' s wounds were cleansed, covered with Silvadene, and a border dressing was applied. Additionally, the note indicated that 911 was called and the resident was transported to the hospital for further evaluation. An emergency department (ED) note dated [DATE] revealed that resident #10 presented to the ED with burns to this right hip, thigh flank area after oxygen tubing caught fire while the resident was smoking during supplemental oxygen use. The note indicated that the resident ' s symptoms included pain. The intervention noted was bandage applied. The note cited that resident sustained 3rd degree burn in a small area on right side. The plan of care indicated was to have resident follow-up with outpatient wound clinic. It was noted that the injury did not require skin graft. Further description of the burn indicated that it was approximately a 5 x 8 cm area that may be full-thickness burn with some surrounding erythema (redness) and blistering. The resident ' s disposition was listed as home discharge. Further review of the ED noted revealed a provider which described the encounter as resident presented to ED with burns to right hip, thigh area after oxygen tubing caught on fire as he was smoking during supplemental oxygen use. The note indicated that the resident stated that he dropped his cigarette on his sweatpants and it started to smolder. The note stated that the resident could not assist himself and stated that I do not have any legs. The note documented that the resident ' s friends had to respond by using a blanket to put the fire out. An emergency room (ER) discharge instruction dated [DATE] revealed that resident #10 was diagnosed with second degree burn of flank and third degree burn of flank. The instruction indicated for the resident to follow-up with the wound clinic that week due to the likelihood that the skin will need debrided. A smoking care plan revised on [DATE] revealed resident required supervision. Interventions indicated that to ensure safety while smoking, the resident required staff supervision. - Regarding resident #75 Resident #75 was admitted to the facility on [DATE] with a diagnosis of orthostatic hypotension, chronic obstructive pulmonary disease, and cervicogenic headache. A smoking care plan initiated on [DATE] indicated a goal for the resident to smoke safely. Interventions included for facility staff to supervise resident #75 while smoking at designated times and that facility will store smoking materials between designated times. However, review of the resident's smoking evaluation dated [DATE] indicated that the resident did not require any supervision or one to one assistance. The evaluation stated that the facility did need to store the resident's lighter and cigarettes. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A progress note dated [DATE] revealed that resident #75 was outside smoking when he gave another resident a cigarette and that resident caught his oxygen (O2) tubing on fire. The note documented that resident #75 turned off the other resident ' s O2 and patted the fire with his right hand to put it out. The note indicated that resident #75 sustained blisters on the tips of his 3 middle fingers and the palm of his hand. The note stated that resident #75 ' s wounds were cleansed and petroleum dressing was applied. Review of the admission MDS dated [DATE] revealed a BIMS score of 15 indicating that the resident was cognitively intact. Resident #25 admitted to the facility on [DATE] with a readmission date of [DATE] with a diagnosis of aftercare following joint replacement surgery, anxiety disorder, depression cognitive communication deficit, bipolar disorder and nicotine dependence. Review of the MDS dated [DATE] revealed a BIMS score of 15, indicating no cognitive impairment. Review of the smoking evaluation dated [DATE] revealed the resident had no cognitive loss, no visual deficit and no dexterity problems. Frequency was 5-10 cigarettes per day and preferred to smoke in the morning, afternoon, evenings and at night. Resident #25 was considered a safe smoker due to she could light her own cigarette and did not require any adaptive equipment such as: a smoking apron, cigarette holder, supervision or one to one assistance. The evaluation stated she could store her own lighter and cigarettes. Review of the State Agency ' s (SA) complaint database revealed a Facility Reported Incident (FRI) submitted on [DATE]. The FRI, indicated that resident #10 was in the designated smoking area when he accidentally dropped his cigarette in his lap, setting himself on fire. An interview was conducted on [DATE] at 1:10 PM with the Executive Director, staff #100. He stated he was in his office getting ready to leave for the day when the Director of Nursing (DON), staff #300, came into his office and told him resident #10 had set himself on fire while smoking. Staff #100 and staff #300 went to resident #10's room to speak with him. Upon entrance, the resident's sweatpants had been removed, he was back in bed, and the nurse was treating his burns. Resident #10 explained he was smoking and he dropped the cigarette on his pants. He was trying to find it, but his pants began smoking and then a fire started. He stated that staff #300 came out and poured a pitcher of juice on his pants and put out the fire. Staff #100 stated that resident #10 has gone back and forth with smoking and not smoking. He had quit for quite some time and just recently started again. He states he completed a BIMS test on him at bedside and resident #10 passed. Staff #300 completed wound care on the resident and paramedics arrived and took resident #10 to the hospital. Staff #100 stated the facility has an open smoking policy, which means residents are assessed to be a safe smoker or a supervised smoker. However, any resident residing in the behavioral unit does require supervision. The most recent evaluation completed on resident #10 prior to the incident was on [DATE] and the resident was deemed a safe smoker. Since this incident, the staff have done a reevaluation and deemed the resident unsafe to smoke on his own and requires supervision. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on [DATE] at 2:54 PM with Resident #10. Upon entrance to his room, it was observed that resident #10 was on a nasal cannula and had a portable oxygen tank on the back of his wheelchair. He stated I just decided to smoke because my friend goes out there and it just looks like they all have a good time so I just decided to start smoking again. I just dropped the cigarette because my hands were slippery, they are just that way. My friend, (resident #75) was out there, he was here before and he just came back. He (resident #75) helped me put the fire out. Then someone came out and threw Gatorade on the flames. I went to the hospital but they did not do much for me really. I don't blame anyone but myself for this. When asked if he had his oxygen on when he went out to smoke, he stated I had the tubing in my nose but I don't think the tank was on because I would've blown up if it was. An interview was conducted on [DATE] at 3:24 PM with Assistant Director of Nursing (ADON), staff # 200. She stated "The process for evaluating a resident as a safe smoker consists of: 1. Identify resident as a smoker. 2. Observe resident smoke. Determine if resident can get the cigarette out of the pack, light the cigarette, hold the cigarette, are cognitive to know what they are doing. 3. Determine if resident can extinguish the cigarette and dispose of it in the container. If they can meet all of these things they are considered a safe smoker and can keep their lighter and cigarettes with them and go in and out on their own. If they are deemed an unsafe smoker, staff keep their cigarettes and lighter. An unsafe smoker will have to inform staff when they want to go out to smoke. Staff will then get their cigarettes and lighter and go out with them to supervise. According to staff #200, resident #10 quit smoking for a long time and just started again. I think it's because his friend (resident #75) was out there. Staff #200 was asked what is the process for a resident smoker who is on oxygen. She stated the oxygen should be turned off and the nasal tubing should be removed before they engage in smoking. Staff #200 indicated that it was unclear if the resident #10 ' s oxygen was off when he went out to smoke. She stated we don't really know for sure because staff did not see what happened. His friend (resident #75) told us the oxygen was off but the cannula was on his face. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on [DATE] at 3:45 PM with Resident #75. He stated I feel like this thing is all my fault. I went out to smoke and resident #10 was there, he's my best friend. He asked me if I had a cigarette and I said yes. I gave him one. Everyone keeps telling me it's not my fault, but if I wouldn't have given him the cigarette, this wouldn't have happened! We were sitting there, and resident #25 was out there too with us, and all of a sudden resident #10's pants started smoking and then a flame came up. I told resident #25 to go and get help. I wheeled myself over to him, and went kind of behind him so I could reach my hand along the side of his pants and put the flames out. As I was doing that, there was a huge whoosh and the flame got bigger. I looked at the oxygen tank and saw it was on and then, the tubing was on fire. I grabbed the tube and pulled it off his face and threw it on the ground. The fire was going up the tubing toward the tank. I was going as fast as I could to turn the tank off and I did. Then the big guy came out with lemonade or whatever is in the pitchers of stuff to drink, he had two of them and poured them on the fire. He's a hero! I just keep blaming myself for giving him that cigarette. I told resident #10, no more, don't ask me for cigarettes anymore because I'm not giving you any. I told him to get a patch. I think he's got the start of dementia or something because he can't remember. Something else, why don't they have signs back there in that area that say if you are on oxygen turn it off before you smoke? Now, I just try to go out and smoke when I know resident #10 is in his room. I just don't ever want to see that happen again. It was just terrible! I was so upset and still am. Again, I know everyone says it's not my fault, but in my mind, if I wouldn't have given him the cigarette that wouldn't have happened. I think I'm traumatized or something. It should be noted that as resident #75 was talking, it was noted that he had a pack of cigarettes between his legs resting on his wheelchair. It was observed that resident #75's right hand had a white gauze wrap around the fingers and top part of his hand. He stated he was burned from trying to help put the fire out that was on resident #10. A follow-up interview was conducted on [DATE] at 4:01 PM with the ADON (staff #200). The ADON stated that when a resident is evaluated, we have them sign a paper that they are educated that if they have oxygen to turn it off and remove the cannula. Residents #10 and #75 were both evaluated as safe smokers but now resident #10 is a supervised smoker. During the interview, the ADON confirmed that if a resident is a safe smoker they can keep their lighter and cigarettes with them, even in their room. Staff #200 stated that she is unsure why resident #75 ' s smoking evaluation indicated that the facility will store his cigarette and lighter since he is deemed a safe smoker. Review of the document signed by resident #10 dated [DATE] states Smoking is prohibited in any area where oxygen is being administered or stored An interview was conducted on [DATE] at 4:45 PM with resident #25. She asked Are you here because of the fire? Resident #25 stated that the incident was terrible! Additionally, resident #25 said that I'm so traumatized by what happened. I cried that night when I went to bed. I just can't believe it! According to (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	resident #25, resident #10 is her friend and he could have died from that incident! In hindsight, she commented that she could not believe that she had not thought think to grab that fire blanket there when she goes past it so many times She noted that she just froze. Resident # 25 commented that it was a good thing resident #75 was there., Resident #75 reacted so fast and then staff #300 came out with 2 pitchers of stuff and poured it on the fire. She stated they are heroes! According to resident #25, resident #75 went over there and started patting at the flames and then this huge whoosh came up. It was awful! She indicated that she froze resident #75 had to yell at her to go get help. She said that she went as fast as she could to get help. Resident #25 stated that resident #10 shouldn't be smoking. He quits then he starts again but he shouldn't do it anymore . She commented that resident #10 has signs of dementia. You can just tell. Review of the facility's policy on Smoking dated [DATE] states This facility has established and maintains safe resident smoking practices. Oxygen use is prohibited in smoking areas. Residents are not permitted to give smoking items to other residents.