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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055979 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/05/2025 |
| NAME OF PROVIDER OR SUPPLIER Franciscan Post-Acute Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 3169 M Street Merced, CA 95348 | |

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) |
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| <p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42123</p> <p>Based on interview and record review, the facility failed to ensure the Minimum Data Set assessment (MDS-a resident assessment tool used to identify resident cognitive and physical function) accurately reflected resident ' s health and functional status for one of three sampled residents (Resident 1) when Resident 1 ' s smoking status and oxygen use were not accurately coded on the MDS assessment.</p> <p>This failure had the potential for Resident 1's smoking and oxygen safety care needs to go unmet. (cross reference F689)</p> <p>Findings:</p> <p>During an interview on 2/5/25 at 9:23 a.m. with the Administrator (ADM), the ADM stated on 2/4/25 around 1:00 a.m., a Certified Nursing Assistant (CNA) heard a loud noise coming from Resident 1 ' s room. The CNA went into the room, and the oxygen tubing and nasal cannula (NC-medical device that provides oxygen through a thin flexible tube with two prongs that fit into the nostrils) were on fire. The ADM stated facility staff were aware Resident 1 was a smoker and would smoke when he was at hemodialysis (HD-a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidneys have failed). The ADM stated Resident 1 had a history of bringing cigarettes back in his belongings when he returned from dialysis.</p> <p>During a review of Resident 1 ' s Admission Record, undated, the admission record indicated, Resident 1 was admitted to the facility on [DATE] with diagnosis that included atrial fibrillation (an irregular and often very rapid heart rhythm), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), end stage renal disease (ESRD-irreversible kidney failure), shortness of breath and dyspnea (difficulty breathing).</p> <p>During a review of Residents 1 ' s MDS assessment dated [DATE], indicated Resident 1 ' s Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 15 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 1 was cognitively intact.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: | Facility ID: 055979 |
| | | If continuation sheet Page 1 of 14 |

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| <p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 2/5/25 at 10:27 a.m. with CNA 2, CNA 2 stated Resident 1 was a known smoker and had been caught smoking at the facility even though the facility was smoke-free. CNA 2 stated the staff was told to make sure Resident 1 was not smoking, have cigarettes or a lighter. CNA 2 stated Resident 1 would go to HD and bring cigarettes and lighters back with him.</p> <p>During a concurrent interview and record review on 2/5/25 at 10:37 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1 had a history of bringing cigarettes and lighters into the facility. Resident 1 's Nursing Note, dated 10/31/24 at 9:05 a.m. was reviewed. The note indicated, . Resident noted to have 8 Norco ' s [medication used to treat severe pain] in his bag, a pocketknife, and a lighter. Educated resident that he cannot have medications, knife, or lighter at bedside. Resident stated that he needs his lighter for when he goes to dialysis. Informed resident that he can take the lighter while he goes out for dialysis, but he needs to give it back to the nurse to put in the narcotic box after he comes back . Resident 1 ' s Nursing Note, dated 10/31/24 at 2:06 p.m. was reviewed, the note indicated, . Resident returned . Lighter put in narcotic [substance used to treat severe pain] box . LVN 1 stated facility was smoke-free but the notes indicated the nurse had given Resident 1 his lighter when he left for dialysis. Resident 1 ' s Order Summary Report, dated 2/2025 was reviewed, the orders indicated, . Administer oxygen @ [at] [SPECIFY] 3 _L/min [liters (unit of measurement) per minute] via nasal cannula, For SOB every shift for Dyspnea . LVN 1 stated Resident 1 had been on oxygen continuously since admission.</p> <p>During a concurrent interview and record review on 2/5/25 at 12:05 p.m. with the Minimum Data Set Coordinator (MDSC), Resident 1 ' s MDS dated [DATE], was reviewed, the MDS indicated, . Section J . Current Tobacco Use [code 0] . No . The MDSC stated Resident 1 was known to smoke when he left for HD and would return smelling like cigarette smoke. The MDSC stated she automatically coded tobacco use as no for all residents because the facility was a smoke-free campus even though she was aware Resident 1 smoked while at dialysis with his oxygen on. The MDSC stated, If you answer yes [on the MDS], then it complicates the report because he is on oxygen. It triggers as critical. The MDSC stated Resident 1 had poor safety awareness and was at high risk for injury. Resident 1 ' s MDS dated [DATE], indicated, . Section O . Oxygen therapy [not marked] . The MDSC stated there was no check mark in the boxes for oxygen therapy which indicated the resident was not on oxygen. The MDSC stated Resident 1 had been on oxygen continuously since admission, so the MDS was not accurate. The MDSC stated it was very important for the MDS assessments to be accurate because it supports the resident ' s care needs to improve their health while in the facility.</p> <p>During a concurrent interview and record review on 2/5/25 at 1:10 p.m. with the Director of Nursing (DON), Resident 1 ' s MDS dated [DATE], was reviewed. The DON stated Section J did not indicate Resident 1 was a tobacco user. The DON stated the MDS ' for the facility residents were always coded no because the facility was smoke-free. The DON declined to answer if the MDS was accurate. Resident 1 ' s MDS dated [DATE] was reviewed, the DON stated oxygen use was not checked, and Resident 1 was admitted with oxygen, so it should have been answered yes.</p> <p>(continued on next page)</p> | | |

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| <p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During a review of the facility ' s policy and procedure (P&P) titled Resident Assessment, dated 11/2017, the P&P indicated, . facility will conduct an initial and periodic comprehensive, accurate assessment of a resident ' s functional capacity which will include needs, strengths, goals, life history and preferences . results of the assessment will be used to develop, review and revise the resident ' s comprehensive care plan . The assessments will be conducted by individuals with the knowledge to complete an accurate assessment of relevant care areas and are knowledgeable about the resident ' s status . Individuals participating in the assessment will not willfully and knowingly certify a material or false statement .</p> <p>During a review of a reference located at https://nursinghomehelp.org/wp-content/uploads/2024/01/MDS-AND-CARE-PLANS-RAI.pdf titled MDS Accuracy and Comprehensive Care Plans, undated, the reference indicated, . Accuracy of Assessments . The assessment must accurately reflect the resident ' s status . Facilities are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment . The assessment must represent an accurate picture of the resident ' s status . Accuracy of Assessments: Why . Proper care planning . MDS accuracy: How . Interview the resident . Interview to the family . Interview to the staff . Review the medical record . Observe resident ' s conditions care aspects .</p> <p>Based on interview and record review, the facility failed to ensure the Minimum Data Set assessment (MDS-a resident assessment tool used to identify resident cognitive and physical function) accurately reflected resident's health and functional status for one of three sampled residents (Resident 1) when Resident 1's smoking status and oxygen use were not accurately coded on the MDS assessment.</p> | | |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42123</p> <p>Based on interview and record review, the facility failed to develop and implement a person-centered comprehensive care plan to prevent accidents for one of three sampled residents (Resident 1) when nursing staff was aware of Resident 1 ' s smoking status, attempts to bring cigarettes and lighters into the facility without staff knowledge and previous attempts at smoking while wearing oxygen at the facility and did not develop and implement effective care plan interventions to prevent smoking related injuries.</p> <p>This failure resulted in Resident 1 suffering second degree burns (injury that damages both the outer layer of skin and part of the underlying layer) requiring transportation to the emergency department (ED) by ambulance, admission to the acute care hospital (ACH) burn unit (a hospital ward that treats patients with burns) and had the potential to cause significant harm to the other residents. (cross reference F689)</p> <p>Findings:</p> <p>During an interview on 2/5/25 at 9:23 a.m. with the Administrator (ADM), the ADM stated on 2/4/25 around 1:00 a.m., a Certified Nursing Assistant (CNA) heard a loud noise coming from Resident 1 ' s room. The CNA went into the room, and the oxygen tubing and nasal cannula (NC-medical device that provides oxygen through a thin flexible tube with two prongs that fit into the nostrils) were on fire. The ADM stated facility staff was aware Resident 1 was a smoker and would smoke when he was at hemodialysis (HD-a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidneys have failed). The ADM stated Resident 1 had a history of bringing cigarettes back in his belongings when he returned from dialysis.</p> <p>During a review of Resident 1 ' s Admission Record, undated, the admission record indicated, Resident 1 was admitted to the facility on [DATE] with diagnosis that included atrial fibrillation (an irregular and often very rapid heart rhythm), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), end stage renal disease (ESRD-irreversible kidney failure), shortness of breath and dyspnea (difficulty breathing).</p> <p>During a review of Residents 1 ' s Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 1 ' s Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 15 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 1 was cognitively intact.</p> <p>During an interview on 2/5/25 at 10:27 a.m. with CNA 2, CNA 2 stated Resident 1 was a known smoker and had been caught smoking at the facility even though the facility was smoke-free. CNA 2 stated the staff was told to make sure Resident 1 was not smoking, have cigarettes or a lighter. CNA 2 stated Resident 1 would go to HD and bring cigarettes and lighters back with him.</p> <p>(continued on next page)</p> | | |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During a review of Resident 1 ' s Nursing Note, dated 2/4/25 at 5:07 a.m., the note indicated, . 0100am [1:00 a.m.] CNA heard a noise coming from room [ROOM NUMBER] [Resident 1 ' s room], Upon entering CNA noted smock [smoke] and fired flames on the floor with nasal cannal [cannula] burning on the floor, CNA immediately put out the fired [sic], Code RED [emergency indicating fire or smoke] was activated . Resident stated I just wanted smoked a cigarette, Resident led [lit] a lighter for a cigarette, Resident was on contentious [continuous] oxygen nasal Cannula, the lighter blew up on his face, CN [charge nurse] noted blood on his mouth and nose and soot all over face, noted soot stains in bed matters [mattress], Noted resident in a sitting position . took resident to hospital for eval and TX [treatment] .</p> <p>(continued on next page)</p> |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During a concurrent interview and record review on 2/5/25 at 10:37 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1 had a history of bringing cigarettes and lighters into the facility. Resident 1 's Nursing Note, dated 10/31/24 at 9:05 a.m. was reviewed. The note indicated, . Resident noted to have 8 Norco ' s [medication used to treat severe pain] in his bag, a pocketknife, and a lighter. Educated resident that he cannot have medications, knife, or lighter at bedside. Resident stated that he needs his lighter for when he goes to dialysis. Informed resident that he can take the lighter while he goes out for dialysis, but he needs to give it back to the nurse to put in the narcotic box after he comes back . Resident 1 ' s Nursing Note, dated 10/31/24 at 2:06 p.m. was reviewed, the note indicated, . Resident returned . Lighter put in narcotic [substance used to treat severe pain] box . LVN 1 stated facility was smoke-free but the notes indicated the nurse had given Resident 1 his lighter when he left for dialysis. Resident 1 ' s Order Summary Report, dated 2/2025 was reviewed, the orders indicated, . Administer oxygen @ [at] [SPECIFY] 3 _L/min [liters (unit of measurement) per minute] via nasal cannula, For SOB every shift for Dyspnea . LVN 1 stated Resident 1 had been on oxygen continuously since admission. Resident 1 ' s oxygen therapy care plan dated 10/24/24 was reviewed. The care plan indicated, . change resident position frequently . For residents who should be ambulatory, provide extension tubing . If the resident is allowed to eat, oxygen still must be given to the resident but in a different manner (e.g., changing from mask to a nasal cannula). Return resident to usual oxygen delivery method after the meal . OXYGEN Settings: O2 2-3L via NC . LVN 1 stated Resident 1 had been on oxygen at 3 liters per minute continuously and the interventions should have been individualized to reflect the resident ' s orders and usage. Resident 1 ' s smoker care plan dated 11/10/24 was reviewed, the care plan indicated, . is a smoker or user of electronic cigarette/vape device . Goal . [Resident 1] will not smoke in the facility premises . Interventions . facilities [sic] smoking policy was reviewed and accepted by the resident and /or resident family . resident requires a cigarette holder while smoking . resident requires a smoking apron while smoking . LVN 1 stated Resident 1 ' s care plan was not accurate because the facility was smoke-free and the care plan should not address what equipment to provide for him to smoke. LVN 1 stated the focus should specify if the resident used cigarettes, electronic cigarette or a vape device so the staff was aware of the specific problem. Resident 1 ' s smoking behavior care plan dated 12/6/24 was reviewed and indicated, . Focus . [Resident 1] has a behavior issue risk and benefit of smoking explained. Per patient he smokes outside the dialysis and not in the post acute care center . resident will have fewer episodes of (SPECIFY: behavior) . Anticipate and meet The resident ' s needs . Educate the resident . on successful coping and interaction strategies such as (SPECIFY) . education on risk of smoking with oxygen use provided to patient . Non compliant behavior noted during dialysis days . LVN 1 stated the care plan should not have (SPECIFY) on it. LVN 1 stated the care plans were auto populated with those areas and needed to be edited with accurate, personalized information for each resident. LVN 1 stated Resident 1 ' s care plans did not address his behaviors of sneaking cigarettes into the facility. LVN 1 stated the nurses were locking his cigarettes in the medication cart and giving them to him when he left for dialysis which should have been addressed as an intervention to prevent him from smoking onsite. LVN 1 stated Resident 1 smoked in his room on 2/4/25 which caused his burn injuries, and the care plans were not effective in preventing the incident.</p> <p>(continued on next page)</p> | | |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During a concurrent interview and record review on 2/5/25, at 11:34 a.m. with the Director of Staff Development (DSD), Resident 1 ' s smoker care plan dated 12/6/24 was reviewed. The DSD stated the interventions did not address Resident 1 ' s behaviors and did not meet his safety needs. The DSD stated Resident 1 was non-compliant with the facility rules and education was not an effective intervention. The DSD stated the care plan interventions of using a cigarette holder and smoking apron did not make any sense because the facility was smoke-free. The DSD stated care plans were very important to make sure all staff was aware of the resident ' s identified problems, put a plan in place and provide interventions to keep the residents safe.</p> <p>During a concurrent interview and record review on 2/5/25 at 1:10 p.m. with the Director of Nursing (DON), the DON stated Resident 1 had a history of smoking at dialysis, had been caught smoking at the facility and previously attempted to smoke in the transport van. The DON stated the nurses would check Resident 1 for cigarettes and lighter when he returned from dialysis and lock them up. The DON stated Resident 1 smoked in his room on 2/4/25 and the nasal cannula had caught fire causing burns to his face. The DON stated Resident 1 was admitted to the burn unit at the acute care hospital (ACH). The DON reviewed Resident 1 ' s care plan dated 11/10/24 and stated she did not know why the interventions included the smoking apron and cigarette holder because the resident was not supposed to smoke onsite. The DON stated the care plan was not accurate. The DON stated the staff checked the resident for cigarettes and a lighter when he returned from dialysis and locked them up but she did not know why the intervention was not documented on the care plan. The DON stated the purpose of a care plan was to guide staff for a resident ' s plan of care and the interventions in place to meet the resident goals. The DON stated they should be individualized and specific to each resident. Resident 1 ' s care plan dated 12/6/24 was reviewed, the DON stated she had printed patient education regarding the risk of smoking and went over them with Resident 1 in December, but he continued to smoke when he left for dialysis. The DON stated Resident 1 was known to be non-compliant and the intervention of providing education was not effective.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled Comprehensive Care Plans, dated 11/2017, the P&P indicated, . provide each resident with a person-centered, comprehensive care plan to address the resident ' s medical, nursing, physical, mental and psychosocial needs . facility Interdisciplinary Team (IDT) will develop and implement a comprehensive, person-center care plan for each resident that includes measurable objectives and timeframes that meet a resident ' s medical, nursing, physical, mental, and psychosocial needs . It will drive the type of care and services that a resident receives and will describe the resident ' s medical, nursing, physical, mental and psychosocial needs and preferences; as well as how the facility will assist in meeting these needs and preferences .</p> <p>During a review of a professional reference retrieved from https://www.medicare.gov/what-medicare-covers/what-part-a-covers/whats-a-care-plan-in-skilled-nursing-facilities#:~:text=This%20helps%20keep%20you%20aware,kind%20of%20services%20you%20need titled What ' s a care plan in skilled nursing facilities, undated, the reference indicated, . When your health condition is assessed, skilled nursing facility (SNF) staff prepare or update your care plan . This helps keep you aware of how the care you get will help you reach your health care goals . may include . what kind of services you need . How often you ' ll need the services . What kind of equipment or supplies you need . Your health goal (or goals), and how your care plan will help you reach your goal .</p> <p>(continued on next page)</p> | | |

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| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Based on interview and record review, the facility failed to develop and implement a person-centered comprehensive care plan to prevent accidents for one of three sampled residents (Resident 1) when nursing staff was aware of Resident 1's smoking status, attempts to bring cigarettes and lighters into the facility without staff knowledge and previous attempts at smoking while wearing oxygen at the facility and did not develop and implement effective care plan interventions to prevent smoking related injuries.</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42123</p> <p>Based on observation, interview, and record review, the facility failed to address the risk of fire while smoking for one of three sampled residents (Resident 1), when staff were aware of Resident 1's need for oxygen (a colorless, odorless gas that is essential for life), history of smoking and bringing in cigarettes and lighters into the facility and did not implement effective measures to ensure Resident 1's safety from fire.</p> <p>These failures resulted in Resident 1 smoking unnoticed while wearing oxygen on 2/4/25, catching fire and suffered avoidable second-degree burns (injury that damages both the outer layer of skin and part of the underlying layer) to the face and right forearm, swelling and severe pain, requiring emergency transport to a higher level of care and hospital with a Burn Unit (a hospital ward that treats patients with burns). Resident 1 was admitted to the acute care hospital (ACH) Burn Unit for two days and may suffer pain and scarring (a mark remaining after injured tissue has healed) as a result of the burns and possible reduced mobility.</p> <p>Findings:</p> <p>During an interview on 2/5/25 at 9:23 a.m. with the Administrator (ADM), the ADM stated on 2/4/25 around 1:00 a.m., a Certified Nursing Assistant (CNA) heard a loud noise coming from Resident 1 's room. The CNA went into the room, and the oxygen tubing and nasal cannula (NC-medical device that provides oxygen through a thin flexible tube with two prongs that fit into the nostrils) were on fire. The ADM stated it was reported Resident 1 had blood on his nose, soot (black powder that forms when something is burned) on his face and his beard was burned off. The ADM stated Resident 1, and his roommate Resident 2, were removed from the room and Resident 1 was transported by ambulance to the ACH Burn Unit for treatment. The ADM stated they did not know where the lighter came from. The ADM stated facility staff was aware Resident 1 was a smoker and would smoke when he was at hemodialysis (HD-a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidneys have failed).</p> <p>During a review of Resident 1 's Admission Record, undated, the admission record indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation (an irregular and often very rapid heart rhythm), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), end stage renal disease (ESRD-irreversible kidney failure), shortness of breath and dyspnea (difficulty breathing).</p> <p>During a review of Residents 1 's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 1 's Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 15 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 1 was cognitively intact.</p> <p>(continued on next page)</p> | | |

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| NAME OF PROVIDER OR SUPPLIER Franciscan Post-Acute Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 3169 M Street Merced, CA 95348 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 2/5/25 at 9:38 a.m. with the Maintenance Supervisor (MS), the MS stated he received a call on 2/4/25 around 1:00 a.m. from facility staff and was told there was a fire at the facility. The MS stated when he arrived, the fire department was already at the facility and had reset the fire alarm. The MS stated he walked into Resident 1 ' s room, saw burnt areas on the floor next to the bed and holes burnt into Resident 1 ' s mattress.</p> <p>During a concurrent observation and interview on 2/5/25 at 9:43 a.m. with the Maintenance Supervisor (MS) in Resident 1 ' s room, Resident 1 ' s bedframe was in the room, but the mattress was gone. The MS stated he had removed the mattress and replaced the burnt tiles on the floor. Resident 1 ' s mattress was observed lying on the ground outside and there were three floor tiles next to the mattress. The MS pointed to the blackened areas on the floor tiles and stated they were caused by the nasal cannula landing on the floor when it was on fire. The mattress had five holes in it, the MS pointed to the largest hole which had discolored areas on the foam with an irregular surface and appeared to have melted a small area. The MS stated it was a fire retardant (substance used to slow down or stop the spread of fire) mattress which prevented to mattress from continuing to burn.</p> <p>During an interview on 2/5/25 at 10:10 a.m. with Resident 2 ' s Paid Caregiver (PCG) in Resident 1 and 2 ' s room, the PCG stated she visited Resident 2 over the weekend and saw Resident 1 with a cigarette in the room. The PCG stated Resident 1 had wheeled over to the sliding glass door and opened it part way. The PCG stated she saw the cigarette and asked what Resident 1 was doing and he replied he was going to smoke. The PCG stated, I told him you are not going to smoke that in here. The PCG stated she mentioned Resident 1 ' s cigarette to a staff member, but did not know if anything was done about it.</p> <p>During an interview on 2/5/25 at 10:13 a.m. with CNA 1, CNA 1 stated she normally worked day shift and was responsible to get Resident 1 ready for HD. CNA 1 stated the staff had been notified to watch Resident 1 ' s belongings for cigarettes or lighters because he had previously been caught with them in his room.</p> <p>During an interview on 2/5/25 at 10:27 a.m. with CNA 2, CNA 2 stated Resident 1 was a known smoker and had been caught smoking at the facility even though the facility was smoke-free. CNA 2 stated the staff was told to make sure Resident 1 was not smoking, have cigarettes or a lighter. CNA 2 stated Resident 1 would go to HD and bring cigarettes and lighters back with him.</p> <p>During a review of Resident 1 ' s Nursing Note, dated 2/4/25 at 5:07 a.m., the note indicated, . 0100am [1:00 a.m.] CNA heard a noise coming from [Resident 1 ' s room], Upon entering CNA noted smock [smoke] and fired flames on the floor with nasal cannula [cannula] burning on the floor, CNA immediately put out the fired [sic], Code RED [emergency indicating fire or smoke] was activated . Resident stated I just wanted smoked a cigarette, Resident led [lit] a lighter for a cigarette, Resident was on contentious [continuous] oxygen nasal Cannula, the lighter blew up on his face, CN [charge nurse] noted blood on his mouth and nose and soot all over face, noted soot stains in bed matters [mattress], Noted resident in a sitting position . took resident to hospital for eval and TX [treatment] .</p> <p>During a review of Resident 1 ' s Nursing Note, dated 2/4/25 at 5:30 a.m. indicated, . resident was admitted to Burn Unit [name of hospital] .</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>During a review of Resident 1 ' s Nursing Note, dated 2/4/25 at 10:26 a.m., the note indicated, . CN called [name of ACH] for an update . resident is currently in the ER [emergency room] trauma unit [hospital department which treats patients with severe injuries], he will be admitted to the burn center . has superficial partial thickness burns [burn that damages the top two layers of skin] to his face, over his nose, left eye, and mouth area. He also has swelling to the left eye and lips .</p> <p>During a concurrent interview and record review on 2/5/25 at 10:37 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1 had a history of bringing cigarettes and lighters into the facility. Resident 1 ' s Nursing Note, dated 10/31/24 at 9:05 a.m. was reviewed. The note indicated, . Resident noted to have 8 Norco ' s [medication used to treat severe pain] in his bag, a pocketknife, and a lighter. Educated resident that he cannot have medications, knife, or lighter at bedside. Resident stated that he needs his lighter for when he goes to dialysis. Informed resident that he can take the lighter while he goes out for dialysis, but he needs to give it back to the nurse to put in the narcotic box after he comes back . Resident 1 ' s Nursing Note, dated 10/31/24 at 2:06 p.m. was reviewed, the note indicated, . Resident returned . Lighter put in narcotic [substance used to treat severe pain] box . LVN 1 stated facility was smoke-free but the notes indicated the nurse had given Resident 1 his lighter when he left for dialysis. LVN 1 stated the nurses kept Resident 1 ' s cigarettes and lighter locked in the medication cart if they were aware he had them, but he was found with them in his room, so it was not always effective. Resident 1 ' s Order Summary Report, dated 2/2025 was reviewed, the orders indicated, . Administer oxygen @ [at] [SPECIFY] 3_L/min [liters (unit of measurement) per minute] via nasal cannula, For SOB every shift for Dyspnea . LVN 1 stated Resident 1 had been on oxygen continuously since admission. The medication cart narcotic drawer was observed, there were two lighters in the cart, but neither belonged to Resident 1.</p> <p>During an interview on 2/5/25 at 12:44 p.m. with the Admissions Coordinator (AC), the AC stated it was her responsibility to review the admission documents with the residents and have the signed. The AC stated when Resident 1 was admitted , she reviewed the facility ' s smoking policy and procedures (P&P) with him and had notified him it was a smoke-free facility. The AC stated when she gave Resident 1 resident a copy of the P&P, the resident became upset, crumpled up the P&P and threw it on the bed.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>During a concurrent interview and record review on 2/5/25 at 1:10 p.m. with the Director of Nursing (DON), Resident 1 ' s Nursing Note, dated 12/4/24 at 1:04 p.m. was reviewed. The note indicated, . [Name of Resident 1 ' s responsible party] said that she did not give him cigarettes. He is asking a driver to buy him cigarette . Per Resident daughter [name] he had accident in the past while smoking with oxygen on . The DON stated she contacted Resident 1 ' s daughter because the facility staff was concerned, he was smoking at dialysis with his oxygen on. The DON stated Resident 1 ' s daughter told her about the resident smoking with oxygen on was nothing new and he would not stop because he was stubborn. The DON stated the nurses would check Resident 1 for cigarettes and lighter when he returned from dialysis and would lock them up. The DON was aware the staff gave Resident 1 his cigarettes when he left for dialysis with oxygen on. The DON stated Resident 1 would smell like smoke when he returned from dialysis. The DON stated on 11/10/24, Resident 1 was caught smoking in his room with oxygen on. Resident 1 ' s IDT (Interdisciplinary team-involves team members from different disciplines working collaboratively, with a common purpose to set goals, make decisions and share resources for the best interest of the resident) note dated 11/11/24 was reviewed, the note indicated, . spoke with [Resident 1] on 11/8/24 about being a nonsmoking facility. [Resident 1] was subsequently found to be smoking outside of his sliding door on 11/10/24 . spoke with him again [sic] today and reminded him that there is no smoking allowed in this facility. Writer offered to refer him to another facility or to get an order for a nicotine patch. [Resident 1] declined both options . The DON stated on 1/10/25 the transportation company had notified her he tried to smoke in the van, and they threatened to stop transporting him. The DON stated the facility did not investigate why the nurses were giving Resident 1 his cigarettes and lighter when he left for dialysis and stated they should not have. The DON stated Resident 1 was admitted to the burn unit at the ACH on 2/4/25. Resident 1 ' s care plan dated 11/10/24 was reviewed, the care plan indicated, . Focus . [Resident 1] is a smoker . Goal . will not smoke in the facility premises . Interventions . The facilities [sic] smoking policy was reviewed and accepted by the resident and/or resident family . The resident requires a cigarette holder while smoking . the resident requires a smoking apron while smoking . The DON stated the campus was smoke-free and she did not know why the interventions included the smoking apron and cigarette holder because the resident was not supposed to smoke onsite. The DON stated the care plan was not accurate. The DON stated the purpose of care plans were to guide staff on the plan of care and interventions to meet the resident goals. The DON stated they should be individualized and specific to each resident. Resident 1 ' s care plan dated 12/6/24 was reviewed and indicated, . behavior issue risk and benefit of smoking explained. Per patient he smokes outside the dialysis and not in post acute care center premises . Goal resident will have fewer episodes . education on risk of smoking with oxygen use provided to patient. Non compliant behavior noted during dialysis days . The DON stated Resident 1 was provided education to not smoke while on oxygen. The DON stated Resident 1 was known to be non-compliant and the intervention of providing education was not effective.</p> <p>During an interview on 2/5/25 at 2:16 p.m. with the ADM, the ADM stated Resident 1 had a history of smoking in the facility. The ADM stated on 11/8/24 Resident 1 had gone outside his room to smoke. The ADM stated the IDT met to discuss interventions for the resident ' s care. The ADM stated the facility had Resident 1 sign a risk versus benefit form regarding smoking while on oxygen. Resident 1 ' s nurse ' s notes dated 10/31/24 indicated, Resident 1 left for dialysis and the nurse had given him the lighter while wearing oxygen. The ADM stated he was aware Resident 1 ' s cigarettes were kept in the medication cart and given to him when he left for dialysis, but did not know the nurses had provided him the lighter while he wore oxygen. The ADM stated, We cannot control what he does when he is out of the facility. The ADM stated, He is going to do what he is going to do. The ADM stated Resident 1 had a right to not be searched when he returned from dialysis.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>During a telephone interview on 2/5/25 at 5:08 p.m. with CNA 3, CNA 3 stated Resident 1 was rebellious. CNA 3 stated the staff frequently caught Resident 1 returning from HD with cigarettes and a lighter and he would smell like smoke when he returned. CNA 3 stated he worked the evening shift on 2/3/25 when Resident 1 returned from dialysis and checked his fanny pack. CNA 3 stated he did not find any cigarettes or a lighter which was unusual because Resident 1 normally had them when he returned.</p> <p>During a telephone interview on 2/5/25 at 5:23 p.m. with LVN 2, LVN 2 stated she was the charge nurse on duty during Resident 1 ' s incident on 2/4/25. LVN 2 stated she heard a CNA yell for her and went into Resident 1 ' s room. LVN 2 stated there was smoke coming out of the room and there was a fire on the ground that the CNA was trying to put out. LVN 2 stated they took the residents out of the room and pulled the fire alarm. LVN 2 stated she assessed Resident 1, and he had blood coming out of his nose and mouth and his face was black with soot. LVN 2 stated Resident 1 ' s face was smoking where his beard had been burned. LVN 2 stated the resident told her he just wanted a cigarette and when he lit the lighter, the nasal cannula caught on fire, and he threw it on the ground. LVN 2 stated Resident 1 had a lighter and cigarette with him, but she did not know where he had gotten them from. LVN 2 stated the CNAs searched Resident 1 ' s belongings and found more cigarettes. LVN 2 stated Resident 1 was on oxygen continuously and should not have been smoking.</p> <p>During a telephone interview on 2/6/25 at 7:21 a.m. with CNA 4, CNA 4 stated he was on duty at the time of Resident 1 ' s accident. CNA 4 stated he was in a room nearby and heard a loud noise coming from Resident 1 ' s room so he went in there. CNA 4 stated there was smoke everywhere and he saw the nasal cannula on fire on the ground. CNA 4 stated he turned off the oxygen concentrator (medical device that gives you extra oxygen) and put the fire on the ground out by stomping on it. CNA 4 stated Resident 1 ' s face was black, and his beard was burnt, and smoking and he had blood coming out of his mouth. CNA 4 stated, He looked shocked and wasn ' t saying anything, just quiet then said, ' the thing blew up ' and he ' wanted to go for a puff ' .</p> <p>During a review of Resident 1 ' s Acute Care Hospital ED [emergency department] Provider Notes, dated 2/4/25, indicated, . Chief Complaint . Burn . 2nd degree burns to face and right forearm from lighting cigarette while on oxygen . Face . Partial thickness burns to the left cheek. Superficial burns to the left eyelid. Burns to the lip. Soot noted in the nose. Singed hair to the face .</p> <p>During a review of Resident 1 ' s ACH document titled History and Physical (H&P) dated 2/4/25, the H&P indicated, . He went to hemodialysis yesterday . he decided to have a cigarette while wearing his oxygen. He accidentally ignited the oxygen and suffered facial burns . Patient reports smoking about 4 cigarettes a day on days he goes to dialysis . burns are second degree . burn wounds with left eye swollen shut, lip and cheek swelling . A: [assessment] 1st and 2nd degree burn of face from contact with fire . Anticipate facial swelling, recommend nasal cannula in place at all times to stent [maintain pressure to promote healing] open the nostrils .</p> <p>During a review of Resident 1 ' s ACH document titled Burn Surgical Service, dated 2/4/25, the note indicated, . sustaining facial burns from smoking while using O2 [oxygen] . P: [plan] . Admit to Burn service . MMPC [multimodal pain control-treatment plan using multiple medications and therapies to control pain] . wound care . nothing by mouth for now .</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>During a review of Resident 1 ' s ACH document titled Discharge Summary, dated 2/6/25, the DC summary indicated, . Patient c/o [complains of] nasal dryness with scab [protective crust that forms over a wound] formation making it difficult to breath[e] through his nose. He has some dyspnea [difficulty breathing] . 02/06 . Reports feeling better today but still reports pain in his face . Patient can be discharged today back to his skilled nursing facility .</p> <p>During a review of the facility ' s policy and procedure (P&P) titled Quality of Care Accident Hazards/Supervision/Devices, dated 7/2018, the P&P indicated, . provide an environment that is free from controllable accident hazards and provision of supervision and devices needed to prevent avoidable accidents . facility recognizes the high-risk nature of the facility population and setting . Efforts to minimize risk to residents will include individualized, resident-centered interventions to reduce individual risks related to hazards in the environment. Interventions will be modified when necessary . Identification of potential hazards in the resident environment and the risk of a resident having an avoidable accident . Identification of or development of interventions based on the severity of the hazard and immediacy of risk . Care plan intervention will be monitored for effectiveness and modified as necessary to increase effectiveness .</p> <p>During a review of the facility ' s P&P titled Physical Environment Smoke Free Facility, dated 3/2019, the P&P indicated, . provide a safe environment for residents . facility shall be designated smoke free . residents, visitors, contractors and staff are not permitted to smoke on the property at any time . non-smoking policy will be included in the admission packet . Residents will be informed that violation of the facility smoking policy could place the resident at risk for a facility initiated discharge due to endangerment of residents and individuals in the facility . Oxygen Therapy . resident with oxygen delivery systems will be informed of safety precautions and prohibitions for oxygen. Staff will monitor resident for compliance with the safety rules .</p> <p>During a review of a professional reference found at https://www.lung.org/lung-health-diseases/lung-procedures-and-tests/oxygen-therapy/using-oxygen-safely#:~:text=Oxygen%20Therapy,-Oxygen%20survey&text=Oxygen%20is%20a%20safe%20gas,from%20what%20your%20doctor%20prescribed titled Oxygen Therapy: Using Oxygen Safely, dated 12/15/23, the reference indicated, . Materials burn more readily in an oxygen-enriched environment . Oxygen Safety Guidelines . Keep Away from Heat and Flame . [NAME] ' t smoke and don ' t allow others to smoke near you . Keep sources of heat and flame at least five feet away . Always have a fire extinguisher [a portable devices that extinguishes a fire] nearby .</p> | | |