

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065272	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER Sierra Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1432 Depew St Lakewood, CO 80214	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</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** 40960</p> <p>Based on observations, record review and interviews, the facility failed to ensure the resident environment remained as free from accident hazards as possible, affecting one (#1) out of three residents reviewed for accident hazards of three sample residents.</p> <p>The facility failed to provide adequate supervision during a smoking break to a resident, who required the use of oxygen.</p> <p>On 8/21/24 Resident #1 exited the behavioral health secured unit door and entered the smoking patio with his oxygen tank and nasal cannula on his face. Certified nurse aide (CNA) CNA #1 and CNA #2 were present to supervise the resident smoking session. CNA #1 was handing out the cigarettes to the residents and CNA #2 was lighting the cigarette for the residents. Resident #1 reached over other residents for his cigarette and CNA #1 handed him a cigarette. Resident #1 proceeded to the line to get his cigarette lit. CNA #2 lit his cigarette but did not observe that the resident's oxygen was in place. Resident #1 proceeded to a chair in the corner of the smoking patio and began smoking his cigarette. CNA #1 and CNA #2 saw another resident running towards Resident #1 and patting his hair which was on fire. Both CNAs ran to Resident #1 and the fire had already been extinguished. CNA #2 immediately removed the resident's nasal cannula and oxygen tank. CNA #2 turned the oxygen off and both CNAs escorted the resident to the nurse's station. The nurse immediately called 911 and sent Resident #1 to the hospital related to the burns on his face.</p> <p>Due to the facilities failure to ensure adequate supervision while residents were smoking, Resident #1 sustained burns to his forehead, tip of his nose, both nostrils, upper and lower lip and his cheeks.</p> <p>Findings include:</p> <p>Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 9/4/24 to 9/5/24, resulting in the deficiency being cited as past noncompliance with a correction date of 8/21/24.</p> <p>I. Accident investigation</p> <p>The 8/20/24 accident investigation was provided by the NHA on 9/4/24 at 10:30 a.m.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The investigation documented the nurse was alerted by CNA #1 and CNA #2 that Resident #1 had been burned when his oxygen ignited while he was smoking on 8/20/24 at approximately 4:00 p.m.</p> <p>The nurse completed first aide to Resident #1 while waiting for emergency medical services (EMS) to arrive. The paramedics took over the resident's care of the visible burns and were attempting to keep his airway clear. The resident was sent to the emergency department. The hospital notes revealed that soot (ashes from the fire) was present in the posterior oropharynx (the back wall of the throat).</p> <p>The physician, the police, the nursing home administrator (NHA), the director of nursing (DON), the ombudsman and the resident's guardian were notified of the incident.</p> <p>The staff members that were involved were provided education on the smoking policy and suspended pending an investigation.</p> <p>Resident #1 was interviewed by the nurse and the DON immediately following the incident. Resident #1 said he was sorry that he had forgotten to take his oxygen off before entering the smoking patio. He said he was afraid he had ruined the smoking session for everyone. He said his face hurt.</p> <p>When Resident #1 returned from the hospital, the nurses progress note on 8/22/24, stated he said the staff had saved his life and that he was so happy to be home.</p> <p>II. Facility corrective action</p> <p>A. Immediate action</p> <p>The NHA, the police department, the DON, the ombudsman and the resident's legal guardian were notified of the incident.</p> <p>Resident #1 was immediately transferred to the hospital for evaluation and treatment of his burns.</p> <p>The two employees that were involved were immediately educated on the smoking policy and suspended pending an investigation. All staff working in the facility at the time of the incident were provided reeducation on the smoking policy.</p> <p>The following day (8/21/24) the remainder of facility staff were reeducated on the smoking policy with return demonstration.</p> <p>B. Interventions put into place</p> <p>The facility reviewed their current policy 8/20/24, to ensure appropriate procedures were in place to prevent harm /potential harm. The policy met all the criteria of what was needed and all of the staff were reeducated on the smoking policy. The incident was in violation of the policy and procedure, so all of the residents who smoked and all of the staff present at the time of the incident were educated on the policy immediately that day (8/20/24). In addition, all staff that were not present were educated the following day (8/21/24). The NHA would ensure that all newly hired staff would receive education on safe smoking and the facility policy.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The education given included the following information:</p> <p>Smoking while using oxygen can be extremely dangerous and can lead to serious consequences. Oxygen is a medical gas that can increase the risk of fire when used in the presence of smoking. While oxygen itself isn't flammable, an oxygen-rich environment can cause materials to ignite more easily and burn faster. This includes flammable substances like cigarettes, which can burn hotter and faster in an oxygen rich environment. Oxygen molecules can also cling to clothing, hair, skin and ignite if they come into contact with the flame.</p> <p>Smoking while using oxygen can lead to catastrophic consequences, including severe injuries, property damage, and loss of life. Some people have been left with serious facial or upper body burns after smoking while on oxygen.</p> <p>It is our responsibility to ensure that we are protecting our residents from harm. It is our job to ensure that residents who smoke have appropriate personal protective equipment (PPE) if needed and do not have oxygen on. If a known oxygen user is also a smoker, staff is to ensure that the oxygen tank is turned off and left inside the building prior to handing out any cigarettes. Residents smoking times is not a time for staff to be on the phone, texting, or playing games. When supervising a resident smoke break, staff need to be actively supervising the residents.</p> <p>Newly admitted residents would be assessed for history or current smoking upon admission.</p> <p>The facility initiated daily random audits of all three units on 8/21/24 to monitor residents who required supervision for smoking. The monitoring included oxygen use, assistive devices, burn holes in clothing/chair cushions, supervision, that staff had all smoking equipment in their possession and any resident concerns. The DON or designated supervisor was to continue the audits for three months.</p> <p>III. Resident #1</p> <p>A. Resident status</p> <p>Resident #1, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the September 2024 computerized physician orders (CPO), the diagnoses included Schizophrenia (mental disorder that causes abnormal behaviors), other psychoactive substance abuse, chronic obstructive pulmonary disease (COPD), dependence on supplemental oxygen and nicotine dependence.</p> <p>The 8/12/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score (BIMS) of 15 out of 15. He had no behaviors and did not reject care. He was independent with all of his activities of daily living (ADL). He received oxygen therapy.</p> <p>-The MDS assessment did not indicate the resident smoked.</p> <p>B. Record review</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>CNA #1 said CNA #2 was lighting the cigarettes in a separate line. She said Resident #1 sat down to smoke his cigarette as the staff continued to pass and light cigarettes for the other residents in line. She said she saw another resident run up to Resident #1 and pat his hair to put the fire out. She said she yelled to CNA #2 that Resident #1 was on fire while running to the resident. She said by the time she arrived to Resident #1, the fire was already out. She said CNA #2 immediately grabbed the oxygen tank and turned it off. She said the nasal cannula had burned away. She said her and CNA #2 then escorted Resident #1 inside the nurses station for treatment. She said the nurse called 911 and treated the resident's burns while awaiting EMS. She said the resident was then sent to the hospital. She said the DON immediately reeducated her on the smoking policy and she was suspended pending the investigation.</p> <p>CNA #2 was interviewed on 9/5/24 at 9:51 a.m. CNA #2 said it was the normal smoke session and CNA #1 had heard out to the smoking patio while he ran to do something quickly in the office. He said he hurried outside to assist</p> <p>CNA #1. He said CNA #1 had already begun passing cigarettes out. He said he had his lighter and to make the process faster he started to light the cigarettes. He said he lit Resident #1's cigarette but did not notice he was still wearing his oxygen. He said he was not paying attention as well as he should have been. He said Resident #1 walked over to a chair and sat down to smoke his cigarette while he continued to light other resident's cigarettes.</p> <p>CNA #2 said he then heard another resident yelling that his hair was on fire, He said he looked up and saw a resident patting at Resident #1's hair. He said he ran over to the residents and removed the oxygen tank and turned it off. He said the nasal cannula had burned away. He said he and CNA #1 helped the resident back into the building to the nurse's station. He said Resident #1 usually was good about taking his oxygen off and leaving it at the door on his walker. He said everything moved so quickly he did not pay attention to Resident #1's face and nose area. He said the staff had to constantly keep their eye on everyone. He said he still [NAME] guilty for not observing Resident #1's oxygen and lighting his cigarette. He said he was immediately reeducated on the smoking policy and suspended pending an investigation.</p> <p>The NHA was interviewed on 9/5/24 at 10:43 a.m. The NHA said when the incident occurred two CNAs were present. He said Resident #1 required supervision with supervised smoking and was the only resident receiving oxygen therapy in the behavior health unit that smoked. He said the smoking material was kept at the nurse's station for safety and the residents had scheduled smoking times.</p> <p>(continued on next page)</p>		

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