STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105287	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER Westside Oaks Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2061 Hyde Park Rd Jacksonville, FL 32210	

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility and resident records, resident and staff interviews, and a review of the facility's policies titled Abuse, Neglect, Exploitation, Mistreatment, Misappropriation of Property and Injury of Unknown Source Prevention (ANEMMI), and Smoking/Vaping, the facility failed to protect the residents' right to be free from neglect/deprivation of services by Certified Nursing Assistants (CNAs) A, B, D, Registered Nurse (RN) E and the Director of Nursing (DON). The facility failed to ensure sufficient safeguards and supervision to protect the residents' right to be free from neglect, by failing to ensure that CNAs A, B, D, RN E and the DON implemented the facility's Smoking/Vaping policy to prevent four oxygenˆdependent residents (#1, #2, #3 and #4) out of four residents reviewed for smoking, from storing cigarettes and lighters in their rooms, and to prevent two oxygen-dependent residents (#1 and #2) from smoking in their rooms while oxygen was in use. This failure resulted in Resident #1 sustaining second-degree facial burns and respiratory distress after his nasal cannula ignited while he smoked in his room, requiring emergency transfer to a local acute care hospital and subsequent transfer to a burn unit for treatment.Resident #1 was identified on 9/25/24 as unsafely smoking in his room while receiving oxygen. Two nursing notes on 9/25/24, and notes dated 9/5/25, 10/19/25 and 2/27/26 revealed that Resident #1 was found smoking in his room. On 2/27/26, Registered Nurse (RN) E observed Resident #1 smoking in his bathroom at 12:00 PM. She did not retrieve his cigarettes or lighter but notified the Director of Nursing (DON). On 2/27/26 at 10:24 PM, Certified Nursing Assistant (CNA) B observed Resident #1 smoking in his room while she was providing care to his roommate. When CNA B saw Resident #1's nasal cannula ignite, she immediately notified RN F. Code Red (an intercom announcement indicating a fire or smoke emergency alerting staff to activate fire safety protocols) was activated and 911 was called for emergency transport to an acute care hospital for treatment. CNA B stated on 3/30/26 at 3:07 PM that she witnessed Resident #1 smoking in his room six times during the week of the event. She notified the DON but stated she did not collect the resident's smoking supplies due to his aggressive behavior. Staff were aware of Resident #1's unsafe behavior and safety needs but did not take necessary action to avoid actual harm to the resident.The facility failed to effectively implement its Smoking/Vaping policy to prevent residents who smoked, particularly oxygenˆdependent smokers, from smoking in their rooms or possessing smoking materials. As a result, residents who smoked continued to retain cigarettes and lighters, smoked inside the facility (including in rooms of oxygenˆdependent residents), and smoked unsupervised in nonˆdesignated areas, leaving all residents at continued risk for serious injury, harm, impairment, or death.Immediate Jeopardy (IJ) at a scope and severity of K (pattern) was identified at 10:45 AM on 3/30/26.On 2/27/26, Immediate Jeopardy began.On 4/1/26 at 5:45 PM, the Administrator was notified of the IJ determination. IJ templates were provided, and Immediate Jeopardy was ongoing as of the survey exit on 4/1/26.The findings include:Cross reference F689, F835, and F867During a facility tour on 3/30/26 at 9:58 AM, three residents were observed sitting in their wheelchairs inside the facility near the designated smoking area door waiting for staff to open the door for their scheduled smoking period at 10:00 AM. Certified Nursing Assistant (CNA) A, (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	read: Resident will sign a smoking agreement upon admission, which remains in effect throughout the stay. Upon any smoking-related infraction, the resident will be re-educated on the established smoking agreement/policy and safety expectations. A formal warning will be issued, documented, and reviewed with the resident, with acknowledgement obtained when possible. Continued noncompliance will result in progressive warnings in accordance with facility policy, up to and including initiation of the discharge process. Another focus area for Resident #4 was for antipsychotic therapy for a diagnosis of psychosis (initiated on 7/27/25).A review of Resident #4's active physician's orders revealed an order dated 9/5/25 for May go LOA (leave of absence) and to therapeutic visits (including facility events) with responsible party and medications.A review of Resident #4's progress notes from 9/19/24 through 3/31/26 revealed no documented evidence of the resident's noncompliance with the facility's smoking policy.A review of the scanned documents in the resident's electronic medical record revealed that Resident #4 was not issued any Smoking Notices for non-compliance with the facility's smoking policy.A review of Resident #4's Smoking Evaluation, dated 3/2/26, revealed that Resident #4 was deemed a safe smoker and did not require supervision. Resident #4 was admitted on [DATE] and his first smoking evaluation was not completed until 3/2/26, after the 2 27/26 incident involving Resident #1. Per the facility's policy, smoking evaluations were to be conducted upon admission, quarterly, annually, and if there was a significant change in condition. Resident #4 signed the facility's smoking agreement on 7/25/25. On 3/30/26 at 10:35 AM, an interview was conducted with Certified Nursing Assistant (CNA) A who supervised the designated smoking area. CNA A stated the CNAs routinely supervised the designated smoking area and were expected to issue and collect residents' smoking supplies and monitor their safety. CNA A stated most residents who were smokers refused to relinquish their cigarettes and lighters and kept them on their person or in their rooms. CNA A stated she notified the nurse, Assistant Director of Nursing (ADON) or DON when residents refused to surrender their smoking supplies, but nothing happens, and that both the Administrator and DON had long been aware that residents retained smoking materials without enacting effective corrective action. CNA A stated staff training on the smoking policy and oxygen safety was limited to folders left at the nurses' station with a signˆin sheet. No formal, inˆperson instruction or confirmation of understanding was completed. She stated residents were only periodically reminded in resident council not to smoke inside or keep supplies in their rooms or on their person, with no changes made to the facility's policy or practice despite ongoing noncompliance. CNA A stated Resident #1 burned his face in February (2026) after repeatedly smoking in his room while on oxygen and that staff, the Administrator and the DON all knew he had been smoking in his room for a long time. CNA A also stated Resident #2, Resident #1's oxygenˆdependent roommate, also smoked in his room. CNA A stated she personally saw both Residents #1 and #2 smoking in their room during the week of and the week before the burn incident. CNA A confirmed that both residents kept their smoking supplies in their room and stated she did not attempt to confiscate the supplies because of their history of aggression. CNA A stated instead, the facility's leadership was informed of their behaviors without knowing whether any followˆup action was taken. When asked why she did not notify the nursing/management staff immediately after Residents #2, #3 and #4 returned inside with their smoking supplies this morning, she replied that she could not leave the designated smoking area but would notify the appropriate staff as soon as there were no residents in the smoking area.On 3/30/26 at 3:00 PM, an interview was conducted with CNA D who stated she was scheduled to work on 2/27/26 but had called out that day. She stated on 3/30/26 (this morning) at about 8:30 AM, she observed Resident #2 (Resident #1's former roommate and oxygenˆdependent resident) smoking in the bathroom inside his room, and immediately notified the Unit Manager, who then informed the DON. When asked if she confiscated Resident #2's smoking materials, she replied that she did not attempt to take Resident #2's cigarettes or lighter because prior attempts had led to verbal and a threat of physical aggression. She stated when residents refused to surrender smoking materials, she reported it to the Unit Manager or the DON. When asked about resident rounding, she stated that while staff (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	conducted rounds, they were not frequent enough to prevent residents from smoking in their rooms. When asked about training and education related to the smoking policy and

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility documents, resident and staff interviews, and a review of the facility's policy titled Adverse Incident Reporting, the facility failed to ensure the timely reporting of an adverse incident for one (Resident #1) of four residents reviewed. The facility failed to report an adverse incident that occurred on 2/27/26 in which Resident #1 sustained secondˆdegree facial burns and respiratory distress after smoking in his room while on oxygen, requiring his transfer to an acute care facility burn unit for treatment.The findings include: An interview was conducted with Resident #1 on 3/30/26 at 9:51 AM. He was observed lying in bed, awake, wearing his nasal cannula with oxygen flowing. When he was asked about his 2/27/26 incident, he stated he smoked a cigarette in his room while wearing oxygen via nasal cannula, the cannula ignited, and he sustained burns to his face that required transport to the hospital. A review of Resident #1's record revealed that he was admitted to the facility on [DATE], was transferred to an acute care hospital on 2/27/26 and was readmitted on [DATE]. Resident #1 sustained second-degree facial burns and respiratory distress after his nasal cannula ignited while he was smoking in his room while receiving oxygen. His diagnoses included chronic obstructive pulmonary disease (COPD - constriction of the airways and difficulty breathing) with acute exacerbation (sudden, severe worsening); alcohol abuse; noncompliance with other medical treatment and regimen; difficulty in walking; dysphagia (difficulty swallowing); anxiety disorder and mood disorder.A review of Resident #1's Quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 12/24/25, revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15 possible points, indicating intact cognition. He was documented as independent with activities of daily living (ADLs).A review of hospital records revealed that on 2/27/26, Resident #1, diagnosed with Chronic Obstructive Pulmonary Disease (COPD) and receiving oxygen via a nasal cannula at the nursing home, lit a cigarette and sustained superficial partialˆthickness burns of his face with a concern for inhalation injury. He required intubation during transport for airway protection and was accepted by the trauma/burn team. On 2/28/26 at 4:59 AM, he was documented as intubated and sedated, with soot in the nares and oropharynx, and superficial partialˆthickness burns to the bridge of the nose and right cheek. On 3/30/26 at 11:02 AM, the Administrator offered a copy of the facility's Reportable log for the Month of: [DATE] for review. She wrote on the paper the following: 0 (zero) for Feb [Administrator's name]. (photographic evidence obtained) A review of the log revealed that there were no adverse incidents reported in the month of February 2026. When the Administrator was asked to confirm that there were no adverse incidents during the month of February 2026, she confirmed there were none.On 3/30/26 at 3:40 PM, the Administrator offered a copy of the Ad Hoc Quality Assurance and Performance Improvement Meeting dated 2/27/26 for review. The reason for the meeting was noted as Resident smoking in the room. The Data section of the Ad Hoc form stated, Resident smoking in the room with oxygen in place, sustaining second degree burn on the face.An interview was conducted with the Director of Nursing (DON) on 3/30/26 at 4:03 PM. When asked about the incident involving Resident #1 on 2/27/26, he stated he was notified the night of 2/27/26, around 10:00 PM, that Resident #1 had been smoking in his room while on oxygen, and that the nasal cannula had caught fire, with parts of the cannula melting on the floor. The DON stated staff heard the fire alarm, responded to the room, turned off the oxygen, assessed the resident, and called 911. The fire department responded to assess the environment for damage and safety, and EMS (Emergency Medical Services) evaluated Resident #1. The DON states Resident #1 initially refused transport, stating he felt okay, but due to the oxygen use and visible burns around his nose, EMS ultimately transported him to the hospital.An interview was conducted with the Administrator on 3/30/26 at 4:42 PM. When she was asked about the incident involving Resident #1 on 2/27/26, she stated she first became aware of the 2/27/26 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incident involving Resident #1 when the Nursing Supervisor called her at approximately 9:30 PM that evening because she was unable to reach the DON. The Nursing Supervisor reported that Resident #1 had caught himself on fire after attempting to smoke in his room while on oxygen, shortly after returning from the designated smoking area. The Administrator stated she instructed the Nursing Supervisor to complete a full changeˆinˆcondition assessment, including a thorough skin assessment, document the findings, notify the physician, and call 911. She stated she then contacted the DON, relayed the information, and directed him to follow up with the Nursing Supervisor. The DON called the Nursing Supervisor as soon as he was notified. When asked if she notified the Agency for Health Care Administration (AHCA) of this incident by submitting a report, she replied that she did not. She stated she consulted with the Regional Clinical Consultant (RCC) who assisted with evaluations, education, and timelines related to the event, and with the Chief Executive Officer (CEO) on 2/27/26. The Administrator stated she was advised by the RCC and CEO to not report it at this time. The Administrator clarified that they did not explicitly tell her never to report the incident, but they also did not direct her to submit a report. When asked about her understanding of the reporting requirements, the Administrator stated that she believed this incident should have been reported. She further stated that a state survey team arrived on 3/2/26 for the facility's annual survey, and as a result, the reporting of the incident was put on the back burner.During a follow-up interview with the DON on 4/1/26 at 8:10 AM, he confirmed that the 2/27/26 incident involving Resident #1 was not reported to the Agency for Health Care Administration (AHCA) and stated that after reviewing the facility's policy, it should have been reported.An interview was conducted with the CEO on 4/1/26 at 5:26 PM. When asked whether an adverse incident report had been submitted for the 2/27/26 incident in which Resident #1 sustained facial burns after his oxygen nasal cannula ignited while he was smoking in his room, she stated an adverse incident report had not been submitted. When asked to explain why the facility did not submit a report, she stated they did not suspect abuse or neglect and while gathering information about the incident, It felt like the incident did not meet the requirement to submit a report. The CEO was presented with the facility's policy titled Adverse Incident Reporting and she was asked to review the definition of adverse incident, specifically item #7, which read, Any condition that required the transfer of the resident within or outside the center to a unit providing a more acute level of care due to the adverse incident, rather than the resident's condition prior to the adverse incident. After reviewing the policy, the CEO acknowledged that the 2/27/26 incident involving Resident #1 met the definition of an adverse incident and should have been reported. She confirmed that the facility failed to submit the required report.A review of the facility's policy and procedure titled Adverse Incident Reporting (dated 8/22/22), revealed:Policy:Florida Statute 400.147 requires the reporting of Adverse Incidents to the Agency for Health Care Administration.Incidents, accidents and unusual occurrences shall be promptly reported to the Administrator or designee via the Center reporting policy and procedure. The Administrator or designee shall immediately notify the Director of Operations/Corporate Nurse Consultant of any Adverse incidents. The Director of Operations/Corporate Nurse Consultant shall review all Adverse Incident Reports prior to submission.For purposes of reporting to the Agency under this section, the term Adverse Incident means:An event over which center personnel could exercise control, and which is associated in whole or in part with the Center's intervention, rather than the condition for which such intervention occurred, and which results in one of the following:7. Any condition that required the transfer of the resident, within or outside the Center, to a unit providing a more acute level of care due to the adverse incident, rather than the resident's condition prior to the adverse incident.The Center will take timely corrective action to ensure resident safety.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 a review of facility and resident records, resident and staff interviews, and a review of the facility policy titled Smoking/Vaping, the facility failed to ensure residents received adequate supervision and sufficient safeguards to prevent avoidable accidents, by failing to ensure that CNAs A, B, D, RN E and the DON implemented the facility's Smoking/Vaping policy to prevent four oxygenˆdependent residents (#1, #2, #3 and #4) out of four residents reviewed for smoking, from storing cigarettes and lighters in their rooms, and to prevent two oxygen-dependent residents (#1 and #2) from smoking in their rooms while oxygen was in use. This failure resulted in Resident #1 sustaining second-degree facial burns and respiratory distress after his nasal cannula ignited while he smoked in his room, requiring emergency transfer to a local acute care hospital and subsequent transfer to a burn unit for treatment.Resident #1 was identified on 9/25/24 as unsafely smoking in his room while receiving oxygen. Two nursing notes on 9/25/24, and notes dated 9/5/25, 10/19/25 and 2/27/26 revealed that Resident #1 was found smoking in his room. On 2/27/26, Registered Nurse (RN) E observed Resident #1 smoking in his bathroom at 12:00 PM. She did not retrieve his cigarettes or lighter but notified the Director of Nursing (DON). On 2/27/26 at 10:24 PM, Certified Nursing Assistant (CNA) B observed Resident #1 smoking in his room while she was providing care to his roommate. When CNA B saw Resident #1's nasal cannula ignite, she immediately notified RN F. Code Red (an intercom announcement indicating a fire or smoke emergency alerting staff to activate fire safety protocols) was activated and 911 was called for emergency transport to an acute care hospital for treatment. CNA B stated on 3/30/26 at 3:07 PM that she witnessed Resident #1 smoking in his room six times during the week of the event. She notified the DON but stated she did not collect the resident's smoking supplies due to his aggressive behavior. Staff were aware of Resident #1's unsafe behavior and safety needs but did not take necessary action to avoid actual harm to the resident.The facility failed to effectively implement its Smoking/Vaping policy to prevent residents who smoked, particularly oxygenˆdependent smokers, from smoking in their rooms or possessing smoking materials. As a result, residents who smoked continued to retain cigarettes and lighters, smoked inside the facility (including in rooms of oxygenˆdependent residents), and smoked unsupervised in nonˆdesignated areas, leaving all residents at continued risk for serious injury, harm, impairment, or death.Immediate Jeopardy (IJ) at a scope and severity of K (pattern) was identified at 10:45 AM on 3/30/26.On 2/27/26, Immediate Jeopardy began.On 4/1/26 at 5:45 PM, the Administrator was notified of the IJ determination. IJ templates were provided, and Immediate Jeopardy was ongoing as of the survey exit on 4/1/26.The findings include:Cross reference F600, F835, and F867During a facility tour on 3/30/26 at 9:58 AM, three residents were observed sitting in their wheelchairs inside the facility near the designated smoking area door waiting for staff to open the door for their scheduled smoking period at 10:00 AM. Certified Nursing Assistant (CNA) A, assigned to supervise the residents who smoked, opened the door leading to the designated smoking area (back porch) at 10:00 AM. CNA A did not provide the three residents with smoking materials; all three residents had cigarettes and lighters already in their possession. At 10:16 AM, all three residents left the designated smoking area and re-entered the facility without providing their smoking materials to CNA A for storage in the smoking area locked cart.Another tour of the facility on 3/30/26 at 10:45 AM revealed that the same three residents who had not relinquished their smoking materials to CNA A in the designated smoking area at 10:16 AM were assigned to rooms [ROOM NUMBERS]. room [ROOM NUMBER] (Residents #2 and #4) and room [ROOM NUMBER] (Resident #3) had Oxygen in Use/No Smoking signs posted on the door frames outside of the rooms.1.A review of Resident #1's medical record revealed that he was admitted to the facility on [DATE], was transferred to an acute care hospital on 2/27/26 and was re-admitted on [DATE]. His diagnoses included chronic obstructive (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	pulmonary disease (COPD - constriction of the airways and difficulty breathing) with acute exacerbation (sudden, severe worsening); alcohol abuse; noncompliance with other medical treatment and regimen; difficulty in walking; dysphagia (difficulty swallowing); anxiety disorder and mood disorder.A nursing note authored by Registered Nurse (RN) E on 2/27/26 revealed that she heard Certified Nursing Assistant (CNA) B scream that Resident #1's oxygen tubing was on fire and entered the room to find the nasal cannula tubing burning, a cigarette on the floor, and smoke spreading throughout the room. The nurse paged a Code Red (an intercom announcement indicating a fire or smoke emergency alerting staff to activate fire safety protocols) and obtained a fire extinguisher while another staff member called 911. RN E then provided care to the resident.A Change in Condition form, completed by RN F on 2/27/26 at 10:35 PM, noted that Resident #1's oxygen tubing caught fire while he was smoking in his room, resulting in burns to his nose and right cheek with pain rated at a 4 on a scale of zero through 10 with 10 being the worst possible pain. He was documented with increased confusion, general weakness, dizziness, unsteadiness, and labored, rapid breathing. His oxygen saturation was 98% on room air, he was a full code, and primary care was notified on 2/27/26 at 10:42 PM with orders to send him to the emergency room. Emergency Medical Services (EMS)/911 was called, and family was notified.A review of the resident's active physician's orders revealed that on 2/28/26, a physician's order was placed to send the resident to the Emergency Department (ED) for evaluation and treatment.A review of the February 2026 medication administration record (MAR) and treatment administration record (TAR) revealed that Resident #1's oxygen was delivered continuously via nasal cannula at 2 LPM according to the nurses' documentation of task completion from 2/1/26 - 2/27/26. The MAR/TAR included documentation of Resident #1's hospital/ED (Emergency Department) transfer on 2/28/26 at 12:54 AM.A review of hospital records revealed that on 2/27/26, Resident #1, diagnosed with Chronic Obstructive Pulmonary Disease (COPD) and receiving oxygen via a nasal cannula at the nursing home, lit a cigarette and sustained superficial partialˆthickness burns of his face with a concern for inhalation injury. He required intubation during transport for airway protection and was accepted by the trauma/burn team. On 2/28/26 at 4:59 AM, he was documented as intubated and sedated, with soot in the nares and oropharynx, and superficial partialˆthickness burns to the bridge of the nose and right cheek. An interview was conducted with Resident #1 on 3/30/26 at 9:51 AM. He was observed lying in bed, awake, wearing his nasal cannula with oxygen flowing at 3 liters per minute (LPM). When he was asked about his 2/27/26 incident, he stated he smoked a cigarette in his room while wearing oxygen via nasal cannula, the cannula ignited, and he sustained burns to his face that required emergent transport to the hospital. When asked if he had been educated about the facility's smoking policy prior to the event, he stated he had received education, but he was a 72ˆyearˆold man and would smoke whenever he wanted to. When asked whether he kept his cigarettes and lighter in his room or provided them to the certified nursing assistant (CNA) supervising smokers in the designated smoking area, he stated he did not give his supplies to staff but always kept all his smoking materials with him. When asked if he had smoked in his room prior to the 2/27/26 incident, he stated he had previously smoked in the bathroom of his room (room [ROOM NUMBER]), and in room [ROOM NUMBER]. When asked if nursing staff rounded frequently to check on/supervise the residents in his room, he stated he barely saw anyone come into his room prior to the incident. When asked if he continued to smoke after the 2/27/26 incident, he stated he quit smoking after that event. When he was asked how he obtained his cigarettes and lighters, he stated he would ask other residents to purchase cigarettes and lighters for him or have a personal friend bring them to him. When asked if he informed staff that he had cigarettes and a lighter on his person, he stated he never did. When asked if he knew he was violating the facility's policy, he stated he was aware but did not care. When asked if staff had requested that he relinquish his smoking supplies to them for proper storage, he stated he never gave them anything.A review of Resident #1's active care plans revealed a care plan dated 11/7/23 with a focus area for a risk for complications with respiratory status related to COPD and a requirement for the use of oxygen. The (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	goal was that the resident would display optimal breathing patterns daily through the next review date. The interventions did not include oxygen therapy safety interventions.Resident #1 was care-planned on 10/8/24 with the following focus areas:Behaviors and smoking inside the building with a goal to decrease risk factors of harming himself or others secondary to his behaviors through the next 30 days.He was care-planned for smoking. The goal was that he would not smoke without supervision through the review date. Interventions included notification of the nurse immediately if it was suspected that Resident #1 was violating the smoking policy; The resident required supervision while smoking; The resident was to be educated about the facility's smoking policy and the dangers of smoking in his room. The most recent revision of the interventions was completed on 2/26/25.A review of Resident #1's Quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 12/24/25, revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15 possible points, indicating intact cognition. He was documented as independent with activities of daily living (ADLs).2. On 3/30/26 at 10:00 AM, Resident #2 was observed entering the designated smoking area. Resident #2 did not obtain cigarettes or a lighter from the CNA supervising residents in the smoking area. He agreed to an interview at 10:02 AM. When asked if he received his cigarettes and lighter from the CNA, he stated he always kept his cigarettes and lighter on his person. He removed a pack of cigarettes and a lighter from his left front pants pocket and placed them on the table. When asked if he had received education or information about the facility's rules regarding smoking/smoking safety, he stated he had but he was afraid the staff would steal his cigarettes and lighter if he let them store the smoking supplies. When asked how he obtained his supplies, he stated when he went out on a leave of absence (LOA), he purchased cigarettes and lighters and kept them. He said he intentionally did not disclose to staff that he was in possession of cigarettes and a lighter when he returned from LOA. When he was asked how long he had been keeping smoking supplies on his person, he stated he had done so since he was admitted to the facility. When he was asked if he was oxygen dependent, he stated he wore oxygen mostly at night and as needed; he did not wear it all the time. Resident #2 said that on 2/27/26 at approximately 9:30 PM to 10:00 PM, Resident #1 was smoking in his room when Resident #1's oxygen ignited and burned his face. Resident #2 stated Resident #1 constantly smoked in his room, including in the bathroom, while wearing his oxygen. Resident #2 further stated he was also a smoker who depended on oxygen therapy and that he had previously smoked inside his own room, but that he did not use his oxygen when he went into the bathroom to smoke. He stated he maintained all of his smoking supplies, including cigarettes and lighters, with him at all times. When asked why he did not provide his smoking supplies to the CNA supervising smokers in the designated smoking area today, he stated he was afraid staff would steal them. He said he was familiar with the facility's smoking policy and acknowledged that he knew he was in violation of the policy. He stated the nurses and CNAs sometimes checked on him every few hours, but on most days, he did not see them at all. He said he was able to leave the facility independently and went to the corner store to purchase cigarettes and lighters when he ran out. When he was asked if staff had requested that he surrender his smoking supplies to them for proper storage, he stated they had, but he would not give them his cigarettes or lighter because they will steal them.On 3/30/26 at 10:16 AM, Resident #2 was observed going back inside the facility without providing his smoking materials to the CNA for storage in the designated smoking area locked cart.A review of Resident #2's medical record revealed he was admitted to the facility on [DATE] with diagnoses including COPD with acute exacerbation, wheezing, and alcohol abuse.A review of the resident's Quarterly MDS assessment, dated 3/30/26, revealed that Resident #2 had a BIMS score of 15 out of 15 possible points, indicating intact cognition. He was documented as independent with ADLs.A review of Resident #2's active physician's orders revealed an order dated 5/14/24 for Oxygen at 2L (two liters per minute) per nasal cannula as needed.A review of the resident's active care plans revealed the following focus areas:[Resident #2] prefers to smoke. The care plan was initiated on 10/17/23 with revisions on 7/1/25 and 3/30/26. The goal was to remain a safe smoker through the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	next review date on 4/8/26. A second goal of review smoking policy with resident was initiated on 3/30/26 with a target date of 4/8/26. The second goal was set after the survey began. Interventions initiated on 10/17/23 included encouraging the resident to follow safe smoking guidelines; to explain the smoking policy to the resident; to keep smoking products in a locked cart, and to notify the charge nurse immediately if it was suspected that the resident had violated the facility's smoking policy. None of these interventions had been revised since 10/17/23. On 3/30/26, a new intervention was initiated (after the surveyor's arrival): review smoking policy, educate not to smoke in the room. Under the care plan interventions on three occasions (10/4/24, 10/7/25 and 3/29/26), the following was noted, Resident given a smoking policy reminder and re-educated regarding not smoking inside the building. Under the intervention dated 10/4/24, initiation and revision dates were also documented as 3/31/26. [Resident #2] is/has the potential to be physically aggressive towards others and is known to refuse daily care r/t (related to) poor impulse control. The care plan was initiated on 11/11/23 with a goal that he will not harm self or others through the review date.Resident #2 was care planned for his use of oxygen therapy related to a diagnosis of COPD (initiated 11/21/23) and impaired vision (initiated 7/12/24). A review of Resident #2's progress notes from 9/19/24 through 3/31/26 revealed no documented evidence of the resident's noncompliance with the facility's smoking policy.A review of Resident #2's Smoking Evaluations, dated 7/10/23, 10/17/23, 2/17/24, 3/2/26, and 3/30/26, revealed that Resident #2 was deemed a safe smoker and did not require supervision. According to the facility's policy, smoking evaluations were to be conducted upon admission, quarterly, annually, and if there was significant change in the resident's condition. Resident #2 signed his smoking agreement on 1/16/2025. 3. On 3/30/26 at 10:00 AM, Resident #3 was observed entering the designated smoking area. She did not obtain cigarettes or a lighter from the CNA supervising residents in the smoking area. Resident #3 agreed to an interview at 10:08 AM. She stated she was oxygenˆdependent and she smoked but she emphasized that she did not smoke while wearing her oxygen or inside her room. The smoking porch was the only place she went to smoke. When asked if she received her cigarettes and lighter from the CNA, she stated she did not and that she kept her cigarettes and lighter in her black purse. She further stated she did not give her smoking supplies to staff because she did not trust them and was afraid someone would steal her cigarettes or lighter. She stated she had been educated about smoking safety and was aware of the facility's smoking policy. She knew she was not supposed to keep cigarettes and a lighter on her person but continued to do so due to fear of theft, stating, I am [AGE] years old. If I want to keep my cigarettes and lighter in my purse, I will. She stated she had kept cigarettes and a lighter on her person for as long as she could remember. She obtained them when she went out on LOA with her family, and did not inform staff that she had cigarettes and a lighter when she returned from LOA. She stated she used oxygen when needed at night and had not and would not smoke in her room or while wearing oxygen. She stated she knew that Residents #1 and #2 had been caught smoking many times in the past and that they used to talk about smoking in their rooms while in the designated smoking area. She stated nursing staff usually took a long time to come to her room and would typically come into her room only two to three times a day while she was awake. She said that although the facility had provided education and reminders not to smoke inside, residents continued to smoke inside every day. She stated staff had requested that she relinquish her smoking supplies to them for proper storage, but she has always refused. During the interview Resident #3 removed one pack of cigarettes and a lighter from her black purse. At the conclusion of the interview, Resident #3 placed the pack of cigarettes and lighter back into her black purse and entered the facility at 10:16 AM without providing her smoking supplies to the supervising CNA. She then entered her room (room [ROOM NUMBER]) with the cigarettes and lighter still in her possession.A review of Resident #3's medical record revealed that she was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including COPD, chronic diastolic (congestive) heart failure (CHF - the heart does not pump blood efficiently, leading to fatigue, fluid buildup in the lungs/tissues and shortness of breath), (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Westside Oaks Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2061 Hyde Park Rd Jacksonville, FL 32210	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	shortness of breath, and nicotine dependence.A review of the resident's Quarterly MDS assessment, dated 3/19/26, revealed that Resident #3 had a BIMS score of 13 out of 15 possible points, indicating intact cognition. She was documented as independent with some ADLs, but she required partial to substantial assistance with dressing, toileting, personal hygiene, and wheelchair mobility.A review of Resident #3's medical record revealed an active physician's order, dated 11/14/23, for Oxygen at 2 liters via nasal cannula - as needed for shortness of breath.A review of Resident #3's active care plan revealed the following focus areas:Resident #3 had a care plan focus area for smoking that was initiated on 4/18/23 with the goal that she would not suffer injury from unsafe smoking practice through the next review date. Interventions initiated on 4/18/23 included: Instruct resident about smoking risks and hazards and about smoking cessation aids that are available; instruct resident about the facility policy on smoking: locations, times, safety concerns; monitor oral hygiene and notify charge nurse immediately if it is suspected resident has violated facility smoking policy. Interventions initiated on 4/17/24 included: Assist with removing O2 (oxygen) during smoking times prn (as needed) and observe clothing and skin for signs of cigarette burns. On 3/31/26, after the start of the survey, a new intervention was added: Resident will sign a smoking agreement upon admission, which remains in effect throughout the stay. Upon any smoking-related infraction, the resident will be re-educated on the established smoking agreement/policy and safety expectations. A formal warning will be issued, documented, and reviewed with the resident, with acknowledgement obtained when possible. Continued noncompliance will result in progressive warnings in accordance with facility policy, up to and including initiation of the discharge process.Further review of the resident's care plans revealed that she was care planned for impaired vision (initiated on 10/13/23), noncompliance with care (initiated on 1/19/26), and use of oxygen therapy (initiated on 6/15/24)related to a diagnosis of COPD.A review of Resident #3's progress notes from 9/19/24 through 3/31/26 revealed no documented evidence of the resident's noncompliance with the facility's smoking policy.A review of the scanned documents in the resident's electronic medical record revealed that Resident #3 had not been issued any Smoking Notices for non-compliance with the facility's smoking policy.A review of Resident #3's Smoking Evaluations dated 10/17/23, 2/18/24 and 3/2/26 revealed the following: On 10/17/23, Resident #3 was deemed a safe smoker who did not require supervision. On 2/18/24, the evaluation's Summary of Evaluation indicated that the resident was a safe smoker, but it did not specify whether or not she required supervision (not answered in the assessment). The smoking evaluation dated 3/2/26 revealed in the Summary of Evaluation that Resident #3 was deemed a safe smoker, but she required supervision. The Quarterly Review section of the same evaluation dated 3/2/26 revealed that the resident was a safe smoker and did not require supervision while smoking. Per the facility's policy, smoking evaluations were to be conducted upon admission, quarterly, annually, and if there was significant change in condition. Resident #3 signed her smoking contract on 2/20/2025. 4. On 3/30/26 at 10:00 AM, Resident #4 was observed entering the designated smoking area. He did not obtain cigarettes or a lighter from the CNA supervising residents in the smoking area. He did not agree to an interview in the designated smoking area but stated he would agree to an interview after he finished smoking.On 3/30/26 at 10:16 AM, Resident #4 went back inside the facility without providing his smoking materials to the CNA for storage in the designated smoking area locked cart.During an interview with Resident #4 on 3/30/26 at 11:49 AM in his room, he stated he was Resident #1's roommate at the time Resident #1 sustained facial burns during a smoking accident at night. He stated Resident #1 smoked in the room multiple times a day while wearing oxygen. He further stated both Resident #1 and Resident #2 smoked in the bathroom and that Resident #2 did not wear his oxygen when smoking but Resident #1 always smoked while wearing his oxygen. Resident #4 stated he was also a smoker but did not use oxygen. He stated he kept his cigarettes and lighter on his person and produced two packs of cigarettes from his left pants pocket and a lighter from his right pants pocket. (photographic evidence obtained) Resident #4 stated the nursing staff were delayed in rounding and typically came into the room once in the early morning, once at lunchtime, and (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	once again at dinner. He said he barely saw nursing staff come into the room to check on residents. He said the facility had educated residents about the smoking policy, but that most of the residents who smoked did not listen to or follow the policy. When asked why he kept his cigarettes and lighter on his person instead of providing them to the CNA supervising smokers in the designated smoking area, Resident #4 stated, Just like everyone else, we don't want people stealing our stuff. Resident #4 stated he knew he was not supposed to keep cigarettes and lighters in his room and he acknowledged that he was in violation of the facility's smoking policy. When asked if staff had requested that he surrender his smoking supplies to them for proper storage, he stated they had asked him a few times, but he refused. Resident #4 declined to continue with the interview, stating he wanted to go outside to smoke again. The interview was concluded.A review of Resident #4's medical record revealed an admission date of 7/25/25 with diagnoses including anxiety disorder, major depressive disorder and schizoaffective disorder. Further review of the record revealed that Resident #4 was a current smoker and was not oxygen dependent.Resident #4 was the former roommate of Resident #1, an oxygen-dependent resident who smoked until 2/27/26, and was the current roommate of Resident #2, an oxygen-dependent resident who smoked.The resident's Quarterly MDS assessment, dated 1/28/26, revealed a BIMS score of 15 out of 15 possible points, indicating intact cognition. He was documented as independent with ADLs.A review of Resident #4's active care plan revealed the following focus areas:Resident prefers to smoke. (initiated on 3/2/26 after the 2/27/26 incident involving Resident #1) The goal was that he would safely smoke in the designated smoking area at designated smoking times through the next review date. Interventions initiated on 3/2/26 included Explain smoking policy to resident. Keep smoking products in locked cart. Notify charge nurse immediately if it is suspected resident has violated facility smoking policy. An intervention initiated on 3/31/26 (after the start of the survey) read: Resident will sign a smoking agreement upon admission, which remains in effect throughout the stay. Upon any smoking-related infraction, the resident will be re-educated on the established smoking agreement/policy and safety expectations. A formal warning will be issued, documented, and reviewed with the resident, with acknowledgement obtained when possible. Continued noncompliance will result in progressive warnings in accordance with facility policy, up to and including initiation of the discharge process. Resident #4 was care planned for antipsychotic therapy for a diagnosis of psychosis (initiated on 7/27/25).A review of Resident #4's active physician's orders revealed an order dated 9/5/25 for May go LOA (leave of absence) and to therapeutic visits (including facility events) with responsible party and medications.A review of Resident #4's progress notes from 9/19/24 through 3/31/26 revealed no documented evidence of the resident's noncompliance with the facility's smoking policy.A review of the scanned documents in the resident's electronic medical record revealed that Resident #4 was not issued any Smoking Notices for non-compliance with the facility's smoking policy.A review of Resident #4's Smoking Evaluation, dated 3/2/26, revealed that Resident #4 was deemed a safe smoker and did not require supervision. Resident #4 was admitted on [DATE] and his first smoking evaluation was not completed until 3/2/26, after the 2 27/26 incident involving Resident #1. Per the facility's policy, smoking evaluations were to be conducted upon admission, quarterly, annually, and if there was a significant change in condition. Resident #4 signed the facility's smoking agreement on 7/25/25. On 3/30/26 at 3:07 PM, an interview was conducted with CNA B. She stated she worked from 2:45 PM until 11:15 PM on 2/27/26 and was in the room caring for Resident #1's roommate when at around 10:15 PM, she smelled cigarette smoke, saw Resident #1 smoking and then his nasal cannula caught on fire. She stated she immediately called the nurse, who entered with a fire extinguisher, put out the fire, assessed Resident #1, called 911, and had him transported by EMS (emergency medical services) to the hospital at around 10:45 PM. She stated she had previously seen Resident #1 smoking in his room and had told the DON several times, including having seen him smoke in his room about six times during the week of the burn accident. She stated the DON does not do anything about it. She confirmed that she did not attempt to confiscate Resident #1's cigarettes or lighter because he (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	became aggressive and hid the smoking supplies. When asked about the frequency of resident rounding, she stated CNA rounding was not consistently done every two hours due to the workload, and there was limited supervision. She said she recalled some past training on smoking safety but no formal training after the 2/27/26 incident specific to smoking, the smoking policy, or oxygenˆtherapy safety. She stated the facility had not implemented new measures or interventions to prevent oxygenˆdependent residents from smoking inside despite ongoing noncompliance. She stated, Nothing is done about it.On 3/30/26 at 3:40 PM, an interview was conducted with Licensed Practical Nurse (LPN) C who stated she was familiar with Resident #1. She said she had not personally seen him smoking in his room but frequently noticed a strong cigarette odor coming from the room (room [ROOM NUMBER]) and believed that he was smoking in the room. She stated other staff also told her that Resident #1 and his roommate (Resident #2) had been seen smoking in the bathroom inside their room. She stated this morning at around 8:30 AM, CNA D informed her that Resident #2 had been observed smoking in the bathroom and she had reported it to the DON. LPN C stated there had always been a problem with residents hiding cigarettes, lighters, and smoking in their rooms despite the facility's rules. When asked if the facility had attempted to implement any new interventions to prevent residents from smoking inside the facility, she said she was not aware of any new interventions. She stated she had completed past inˆservice education on the smoking policy, smoking safety, and oxygenˆtherapy safety, and that staff tried to complete rounds at least every two hours but oftentimes could not round timely due to their excessive workload.On 3/30/26 at 3:59 PM, an interview was conducted with Registered Nurse (RN) E who stated she was familiar with Resident #1 and personally witnessed Resident #1 smoking in his room. She reported that on 2/27/26 at around 12:00 PM, she observed Resident #1 smoking inside his room. When asked whether she retrieved cigarettes or a lighter from him at that time, she stated she did not see any cigarettes or lighter on his person or in plain view, and believed he had hidden his smoking materials, as he did not surrender them when asked. RN E stated Resident #1 had been seen smoking in his room on prior occasions and that staff had reported these incidents to her and to the DON. When asked if she reported incidents to the DON, she stated that anytime a staff member reported an incident, the DON was notified immediately. When asked whether the facility had implemented any new interventions specifically to prevent oxygen-dependent residents from smoking in their rooms, she stated she was not aware of any new internal changes directed at oxygenˆdependent smokers after these events. When asked about training, she stated that the majority of the staff received reading material or education after the incident, but she could not recall any focused, formal training specifically addressing smoking safety and oxygenˆtherapy safety beyond what had been provided previously. When asked if she believed that the training provided had been effective, she replied that it had not been effective. She added that most of the training was just a folder with information and a sign-in sheet that the staff had to review and sign. When asked if formal training was ever provided, she stated, rarely. When asked if formal training was provided related to the Smoking Policy after Resident #1's incident, she replied, No.On 3/30/26 at 4:03 PM, an interview was conducted with the DON who stated he was notified at around 10:00 PM on 2/27/26 that Resident #1 had been smoking in his room while on oxygen, that his nasal cannula caught fire and partially melted, and that staff responded to the alarm by turning off the oxygen, assessing the resident, calling 911, and involving the fire department and EMS, who ultimately transported the resident to the hospital. He stated Resident #1 had previously been caught smoking in his room multiple times, received repeated education, and three to four written smokingˆpolicy notices. He st

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility and resident records, facility job descriptions, policies and procedures, and interviews with residents, staff and medical professionals, the facility's Administration failed to provide oversight of the facility in a manner that ensured necessary interventions, including adequate supervision and sufficient safeguards, were in place to prevent avoidable accidents, by failing to ensure that CNAs A, B, D, RN E and the DON implemented the facility's Smoking/Vaping policy to prevent four oxygenˆdependent residents (#1, #2, #3 and #4) out of four residents reviewed for smoking, from storing cigarettes and lighters in their rooms, and to prevent two oxygen-dependent residents (#1 and #2) from smoking in their rooms while oxygen was in use. This failure resulted in Resident #1 sustaining second-degree facial burns and respiratory distress after his nasal cannula ignited while he smoked in his room, requiring emergency transfer to a local acute care hospital and subsequent transfer to a burn unit for treatment.Resident #1 was identified on 9/25/24 as unsafely smoking in his room while receiving oxygen. Two nursing notes on 9/25/24, and notes dated 9/5/25, 10/19/25 and 2/27/26 revealed that Resident #1 was found smoking in his room. On 2/27/26, Registered Nurse (RN) E observed Resident #1 smoking in his bathroom at 12:00 PM. She did not retrieve his cigarettes or lighter but notified the Director of Nursing (DON). On 2/27/26 at 10:24 PM, Certified Nursing Assistant (CNA) B observed Resident #1 smoking in his room while she was providing care to his roommate. When CNA B saw Resident #1's nasal cannula ignite, she immediately notified RN F. Code Red (an intercom announcement indicating a fire or smoke emergency alerting staff to activate fire safety protocols) was activated and 911 was called for emergency transport to an acute care hospital for treatment. CNA B stated on 3/30/26 at 3:07 PM that she witnessed Resident #1 smoking in his room six times during the week of the event. She notified the DON but stated she did not collect the resident's smoking supplies due to his aggressive behavior. Staff were aware of Resident #1's unsafe behavior and safety needs but did not take necessary action to avoid actual harm to the resident.Facility Administration, while aware of a longstanding problem with residents who smoked not adhering to the facility's Smoking/Vaping policy, failed to ensure the implementation of that policy to prevent residents who smoked, particularly oxygenˆdependent smokers, from smoking in their rooms or possessing smoking materials. The Administration also failed to initiate a timely, effective, facilityˆwide corrective action plan, following the 2/27/26 event, that addressed system failures regarding resident assessments for smoking risk, supervision practices and environmental safety controls. As a result, residents who smoked continued to retain cigarettes and lighters, smoked inside the facility (including in rooms of oxygenˆdependent residents), and smoked unsupervised in nonˆdesignated areas, resulting Resident #1 sustaining a serious injury and leaving all residents at continued risk for serious injury, harm, impairment, or death.Immediate Jeopardy (IJ) at a scope and severity of L (widespread) was identified at 10:45 AM on 3/30/26.On 2/27/26, Immediate Jeopardy began.On 4/1/26 at 5:45 PM, the Administrator was notified of the IJ determination. IJ templates were provided, and Immediate Jeopardy was ongoing as of the survey exit on 4/1/26.The findings include:Cross reference F600, F609, F689, and F867During a facility tour on 3/30/26 at 9:58 AM, three residents were observed sitting in their wheelchairs inside the facility near the designated smoking area door waiting for staff to open the door for their scheduled smoking period at 10:00 AM. Certified Nursing Assistant (CNA) A, assigned to supervise the residents who smoked, opened the door leading to the designated smoking area (back porch) at 10:00 AM. CNA A did not provide the three residents with smoking materials; all three residents had cigarettes and lighters already in their possession. At 10:16 AM, all three residents left the designated smoking area and re-entered the facility without providing their smoking materials to CNA A for storage in the smoking area locked cart.Another tour of the facility on 3/30/26 at 10:45 AM revealed that the same three residents who had not relinquished their smoking materials to CNA A in the designated smoking area (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	at 10:16 AM were assigned to rooms [ROOM NUMBERS]. room [ROOM NUMBER] (Residents #2 and #4) and room [ROOM NUMBER] (Resident #3) had Oxygen in Use/No Smoking signs posted on the door frames outside of the rooms.1.A review of Resident #1's medical record revealed that he was admitted to the facility on [DATE], was transferred to an acute care hospital on 2/27/26 and was re-admitted on [DATE]. His diagnoses included chronic obstructive pulmonary disease (COPD - constriction of the airways and difficulty breathing) with acute exacerbation (sudden, severe worsening); alcohol abuse; noncompliance with other medical treatment and regimen; difficulty in walking; dysphagia (difficulty swallowing); anxiety disorder and mood disorder.A nursing note authored by Registered Nurse (RN) E on 2/27/26 revealed that she heard Certified Nursing Assistant (CNA) B scream that Resident #1's oxygen tubing was on fire and entered the room to find the nasal cannula tubing burning, a cigarette on the floor, and smoke spreading throughout the room. The nurse paged a Code Red (an intercom announcement indicating a fire or smoke emergency alerting staff to activate fire safety protocols) and obtained a fire extinguisher while another staff member called 911. RN E then provided care to the resident.A Change in Condition form, completed by RN F on 2/27/26 at 10:35 PM, noted that Resident #1's oxygen tubing caught fire while he was smoking in his room, resulting in burns to his nose and right cheek with pain rated at a 4 on a scale of zero through 10 with 10 being the worst possible pain. He was documented with increased confusion, general weakness, dizziness, unsteadiness, and labored, rapid breathing. His oxygen saturation was 98% on room air, he was a full code, and primary care was notified on 2/27/26 at 10:42 PM with orders to send him to the emergency room. Emergency Medical Services (EMS)/911 was called, and family was notified.A review of the resident's active physician's orders revealed that on 2/28/26, a physician's order was placed to send the resident to the Emergency Department (ED) for evaluation and treatment.A review of the February 2026 medication administration record (MAR) and treatment administration record (TAR) revealed that Resident #1's oxygen was delivered continuously via nasal cannula at 2 LPM according to the nurses' documentation of task completion from 2/1/26 - 2/27/26. The MAR/TAR included documentation of Resident #1's hospital/ED (Emergency Department) transfer on 2/28/26 at 12:54 AM.A review of hospital records revealed that on 2/27/26, Resident #1, diagnosed with Chronic Obstructive Pulmonary Disease (COPD) and receiving oxygen via a nasal cannula at the nursing home, lit a cigarette and sustained superficial partialˆthickness burns of his face with a concern for inhalation injury. He required intubation during transport for airway protection and was accepted by the trauma/burn team. On 2/28/26 at 4:59 AM, he was documented as intubated and sedated, with soot in the nares (nostrils) and oropharynx (throat), and superficial partialˆthickness burns to the bridge of the nose and right cheek. An interview was conducted with Resident #1 on 3/30/26 at 9:51 AM. He was observed lying in bed, awake, wearing his nasal cannula with oxygen flowing at 3 liters per minute (LPM). When he was asked about his 2/27/26 incident, he stated he smoked a cigarette in his room while wearing oxygen via nasal cannula, the cannula ignited, and he sustained burns to his face that required emergent transport to the hospital. When asked if he had been educated about the facility's smoking policy prior to the event, he stated he had received education, but he was a 72ˆyearˆold man and would smoke whenever he wanted to. When asked whether he kept his cigarettes and lighter in his room or provided them to the certified nursing assistant (CNA) supervising smokers in the designated smoking area, he stated he did not give his supplies to staff but always kept all of his smoking materials with him. When asked if he had smoked in his room prior to the 2/27/26 incident, he stated he had previously smoked in the bathroom of his room (room [ROOM NUMBER]), and in room [ROOM NUMBER]. When asked if nursing staff rounded frequently to check on/supervise the residents in his room, he stated he barely saw anyone come into his room prior to the incident. When asked if he continued to smoke after the 2/27/26 incident, he stated he quit smoking after that event. When he was asked how he obtained his cigarettes and lighters, he stated he would ask other residents to purchase cigarettes and lighters for him or have a personal friend bring them to him. When asked if he informed staff that he had cigarettes and a lighter on his (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	person, he stated he never did. When asked if he knew he was violating the facility's policy, he stated he was aware but did not care. When asked if staff had requested that he relinquish his smoking supplies to them for proper storage, he stated he never gave them anything.Further review of Resident #1's medical record revealed the following nursing notes:A nursing note dated 9/25/24 at 2:24 PM revealed that Resident #1 was observed smoking cigarettes in his room while connected to his oxygen concentrator. The nurse provided education and informed the resident that smoking in the room, especially while on oxygen, was prohibited and posed a serious safety risk to him and other residents. The nurse then contacted law enforcement to assist with the situation. There was no documented evidence verifying that the nurse requested that the resident relinquish his smoking materials or that she confiscated them.A nursing behavior note dated 9/25/24 at 2:59 PM revealed that the writer noticed a smell of cigarette smoke. She went inside Resident #1's room and found him smoking with his nasal cannula on and oxygen flowing. Resident #1 was asked to extinguish his cigarette, and he put it into a beer can between his feet. Seven beer cans were also found in a trash bag under his bedside table. When staff requested that he relinquish his cigarettes and beer, he refused, became belligerent, and insisted he paid for them. The unit manager and the Director of Nursing (DON) were notified, and law enforcement was called. When law enforcement arrived, the resident denied smoking in the building, stated he did not care about others' safety, and insisted he would keep his cigarettes. He ultimately surrendered five cigarettes from a carton to the officer, who gave them to the nurse and indicated it was a civil matter, advising the unit manager to review the facility's smoking policy and consider discharge options. The DON was briefed on the situation.A nursing note dated 10/19/25 at 3:00 PM revealed that the nurse observed Resident #1 smoking in his room with his oxygen turned off. The nurse noted that education was provided and the DON was notified. The nurse documented the failed attempt to confiscate the resident's smoking materials due to his refusal.A review of Resident #1's active care plans revealed a care plan dated 11/7/23 with a focus area for a risk for complications with respiratory status related to COPD and a requirement for the use of oxygen. The goal was that the resident would display optimal breathing patterns daily through the next review date. The interventions did not include oxygen therapy safety interventions.Resident #1 was care-planned on 10/8/24 with the following focus areas:Behaviors and smoking inside the building with a goal to decrease risk factors of harming himself or others secondary to his behaviors through the next 30 days.He was care-planned for smoking. The goal was that he would not smoke without supervision through the review date. Interventions included notification of the nurse immediately if it was suspected that Resident #1 was violating the smoking policy; The resident required supervision while smoking; The resident was to be educated about the facility's smoking policy and the dangers of smoking in his room. The most recent revision of the interventions was completed on 2/26/25.A review of Resident #1's Quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 12/24/25, revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15 possible points, indicating intact cognition. He was documented as independent with activities of daily living (ADLs).A review of the resident's medical record revealed that on 3/25/26, Resident #1 saw his primary care provider (PCP) for a follow-up after his hospital discharge. The PCP's notes indicated that Resident #1 presented to the hospital on 2/27/26 for respiratory failure, facial and inhalation burns. Her notes also indicated that Resident #1 was intubated and admitted to the ICU (Intensive Care Unit). 2. On 3/30/26 at 10:00 AM, Resident #2 was observed entering the designated smoking area. Resident #2 did not obtain cigarettes or a lighter from the CNA supervising residents in the smoking area. He agreed to an interview at 10:02 AM. When asked if he received his cigarettes and lighter from the CNA, he stated he always kept his cigarettes and lighter on his person. He removed a pack of cigarettes and a lighter from his left front pants pocket and placed them on the table. When asked if he had received education or information about the facility's rules regarding smoking/smoking safety, he stated he had but he was afraid the staff would steal his cigarettes and lighter if he let them store the smoking (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Westside Oaks Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2061 Hyde Park Rd Jacksonville, FL 32210	

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	change in the resident's condition. Resident #2 signed his smoking agreement on 1/16/2025. 3. On 3/30/26 at 10:00 AM, Resident #3 was observed entering the designated smoking area. She did not obtain cigarettes or a lighter from the CNA supervising residents in the smoking area. Resident #3 agreed to an interview at 10:08 AM. She stated she was oxygenˆdependent and she smoked but she emphasized that she did not smoke while wearing her oxygen or inside her room. The smoking porch was the only place she went to smoke. When asked if she received her cigarettes and lighter from the CNA, she stated she did not and that she kept her cigarettes and lighter in her black purse. She further stated she did not give her smoking supplies to staff because she did not trust them and was afraid someone would steal her cigarettes or lighter. She stated she had been educated about smoking safety and was aware of the facility's smoking policy. She knew she was not supposed to keep cigarettes and a lighter on her person but continued to do so due to fear of theft, stating, I am [AGE] years old. If I want to keep my cigarettes and lighter in my purse, I will. She stated she had kept cigarettes and a lighter on her person for as long as she could remember. She obtained them when she went out on LOA with her family, and did not inform staff that she had cigarettes and a lighter when she returned from LOA. She stated she used oxygen when needed at night and had not and would not smoke in her room or while wearing oxygen. She stated she knew that Residents #1 and #2 had been caught smoking many times in the past and that they used to talk about smoking in their rooms while in the designated smoking area. She stated nursing staff usually took a long time to come to her room and would typically come into her room only two to three times a day while she was awake. She said that although the facility had provided education and reminders not to smoke inside, residents continued to smoke inside every day. She stated staff had requested that she relinquish her smoking supplies to them for proper storage, but she has always refused. During the interview Resident #3 removed one pack of cigarettes and a lighter from her black purse. At the conclusion of the interview, Resident #3 placed the pack of cigarettes and lighter back into her black purse and entered the facility at 10:16 AM without providing her smoking supplies to the supervising CNA. She then entered her room (room [ROOM NUMBER]) with the cigarettes and lighter still in her possession.A review of Resident #3's medical record revealed that she was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including COPD, chronic diastolic (congestive) heart failure (CHF - the heart does not pump blood efficiently, leading to fatigue, fluid buildup in the lungs/tissues and shortness of breath), shortness of breath, and nicotine dependence.A review of the resident's Quarterly MDS assessment, dated 3/19/26, revealed that Resident #3 had a BIMS score of 13 out of 15 possible points, indicating intact cognition. She was documented as independent with some ADLs, but she required partial to substantial assistance with dressing, toileting, personal hygiene, and wheelchair mobility.A review of Resident #3's medical record revealed an active physician's order, dated 11/14/23, for Oxygen at 2 liters via nasal cannula - as needed for shortness of breath.A review of Resident #3's active care plan revealed the following focus areas:Resident #3 had a care plan focus area for smoking that was initiated on 4/18/23 with the goal that she would not suffer injury from unsafe smoking practice through the next review date. Interventions initiated on 4/18/23 included: Instruct resident about smoking risks and hazards and about smoking cessation aids that are available; instruct resident about the facility policy on smoking: locations, times, safety concerns; monitor oral hygiene and notify charge nurse immediately if it is suspected resident has violated facility smoking policy. Interventions initiated on 4/17/24 included: Assist with removing O2 (oxygen) during smoking times prn (as needed) and observe clothing and skin for signs of cigarette burns. On 3/31/26, after the start of the survey, a new intervention was added: Resident will sign a smoking agreement upon admission, which remains in effect throughout the stay. Upon any smoking-related infraction, the resident will be re-educated on the established smoking agreement/policy and safety expectations. A formal warning will be issued, documented, and reviewed with the resident, with acknowledgement obtained when possible. Continued noncompliance will result in progressive warnings in accordance with facility policy, up to and including initiation of (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	the discharge process.Further review of the resident's care plans revealed that she was care planned for impaired vision (initiated on 10/13/23), noncompliance with care (initiated on 1/19/26), and use of oxygen therapy (initiated on 6/15/24)related to a diagnosis of COPD.A review of Resident #3's progress notes from 9/19/24 through 3/31/26 revealed no documented evidence of the resident's noncompliance with the facility's smoking policy.A review of the scanned documents in the resident's electronic medical record revealed that Resident #3 had not been issued any Smoking Notices for non-compliance with the facility's smoking policy.A review of Resident #3's Smoking Evaluations dated 10/17/23, 2/18/24 and 3/2/26 revealed the following: On 10/17/23, Resident #3 was deemed a safe smoker who did not require supervision. On 2/18/24, the evaluation's Summary of Evaluation indicated that the resident was a safe smoker, but it did not specify whether or not she required supervision (not answered in the assessment). The smoking evaluation dated 3/2/26 revealed in the Summary of Evaluation that Resident #3 was deemed a safe smoker, but she required supervision. The Quarterly Review section of the same evaluation dated 3/2/26 revealed that the resident was a safe smoker and did not require supervision while smoking. Per the facility's policy, smoking evaluations were to be conducted upon admission, quarterly, annually, and if there was significant change in condition. Resident #3 signed her smoking contract on 2/20/2025. 4. On 3/30/26 at 10:00 AM, Resident #4 was observed entering the designated smoking area. He did not obtain cigarettes or a lighter from the CNA supervising residents in the smoking area. He did not agree to an interview in the designated smoking area but stated he would agree to an interview after he finished smoking.On 3/30/26 at 10:16 AM, Resident #4 went back inside the facility without providing his smoking materials to the CNA for storage in the designated smoking area locked cart.During an interview with Resident #4 on 3/30/26 at 11:49 AM in his room, he stated he was Resident #1's roommate at the time Resident #1 sustained facial burns during a smoking accident at night. He stated Resident #1 smoked in the room multiple times a day while wearing oxygen. He further stated both Resident #1 and Resident #2 smoked in the bathroom and that Resident #2 did not wear his oxygen when smoking but Resident #1 always smoked while wearing his oxygen. Resident #4 stated he was also a smoker but did not use oxygen. He stated he kept his cigarettes and lighter on his person and produced two packs of cigarettes from his left pants pocket and a lighter from his right pants pocket. (photographic evidence obtained) Resident #4 stated the nursing staff were delayed in rounding and typically came into the room once in the early morning, once at lunchtime, and once again at dinner. He said he barely saw nursing staff come into the room to check on residents. He said the facility had educated residents about the smoking policy, but that most of the residents who smoked did not listen to or follow the policy. When asked why he kept his cigarettes and lighter on his person instead of providing them to the CNA supervising smokers in the designated smoking area, Resident #4 stated, Just like everyone else, we don't want people stealing our stuff. Resident #4 stated he knew he was not supposed to keep cigarettes and lighters in his room and he acknowledged that he was in violation of the facility's smoking policy. When asked if staff had requested that he surrender his smoking supplies to them for proper storage, he stated they had asked him a few times, but he refused. Resident #4 declined to continue with the interview, stating he wanted to go outside to smoke again. The interview was concluded.A review of Resident #4's medical record revealed an admission date of 7/25/25 with diagnoses including anxiety disorder, major depressive disorder and schizoaffective disorder. Further review of the record revealed that Resident #4 was a current smoker and was not oxygen dependent.Resident #4 was the former roommate of Resident #1, an oxygen-dependent resident who smoked until 2/27/26, and was the current roommate of Resident #2, an oxygen-dependent resident who smoked.The resident's Quarterly MDS assessment, dated 1/28/26, revealed a BIMS score of 15 out of 15 possible points, indicating intact cognition. He was documented as independent with ADLs.A review of Resident #4's active care plan revealed the following focus areas:Resident prefers to smoke. (initiated on 3/2/26 after the 2/27/26 incident involving Resident #1) The goal was that he would safely smoke in the designated smoking area at designated smoking (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	times through the next review date. Interventions initiated on 3/2/26 included Explain smoking policy to resident. Keep smoking products in locked cart. Notify charge nurse immediately if it is suspected resident has violated facility smoking policy. An intervention initiated on 3/31/26 (after the start of the survey) read: Resident will sign a smoking agreement upon admission, which remains in effect throughout the stay. Upon any smoking-related infraction, the resident will be re-educated on the established smoking agreement/policy and safety expectations. A formal warning will be issued, documented, and reviewed with the resident, with acknowledgement obtained when possible. Continued noncompliance will result in progressive warnings in accordance with facility policy, up to and including initiation of the discharge process. Another focus area for Resident #4 was for antipsychotic therapy for a diagnosis of psychosis (initiated on 7/27/25).A review of Resident #4's active physician's orders revealed an order dated 9/5/25 for May go LOA (leave of absence) and to therapeutic visits (including facility events) with responsible party and medications.A review of Resident #4's progress notes from 9/19/24 through 3/31/26 revealed no documented evidence of the resident's noncompliance with the facility's smoking policy.A review of the scanned documents in the resident's electronic medical record revealed that Resident #4 was not issued any Smoking Notices for non-compliance with the facility's smoking policy.A review of Resident #4's Smoking Evaluation, dated 3/2/26, revealed that Resident #4 was deemed a safe smoker and did not require supervision. Resident #4 was admitted on [DATE] and his first smoking evaluation was not completed until 3/2/26, after the 2 27/26 incident involving Resident #1. Per the facility's policy, smoking evaluations were to be conducted upon admission, quarterly, annually, and if there was a significant change in condition. Resident #4 signed the facility's smoking agreement on 7/25/25. On 3/30/26 at 10:35 AM, an interview was conducted with Certified Nursing Assistant (CNA) A. CNA A stated the CNAs routinely supervised the designated smoking area and were expected to issue and collect residents' smoking supplies and monitor their safety. CNA A stated most residents who were smokers refused to relinquish their cigarettes and lighters and kept them on their person or in their rooms. CNA A stated she notified the nurse, Assistant Director of Nursing (ADON) or DON when residents refused to surrender their smoking supplies, but nothing happens, and that both the Administrator and DON had long been aware that residents retained smoking materials without enacting effective corrective action. CNA A stated staff training on the smoking policy and oxygen safety was limited to folders left at the nurses' station with a signˆin sheet. No formal, inˆperson instruction or confirmation of understanding was completed. She stated residents were only periodically reminded in resident council not to smoke inside or keep supplies in their rooms or on their person, with no changes made to the facility's policy or practice despite ongoing noncompliance. CNA A stated Resident #1 burned his face in February (2026) after repeatedly smoking in his room while on oxygen and that staff, the Administrator and the DON all knew he had been smoking in his room for a long time. CNA A also stated Resident #2, Resident #1's oxygenˆdependent roommate, also smoked in his room. CNA A stated she personally saw both Residents #1 and #2 smoking in their room during the week of and the week before the burn incident. CNA A confirmed that both residents kept their smoking supplies in their room and stated she did not attempt to confiscate the supplies because of their history of aggression. CNA A stated instead, the facility's leadership was informed of their behaviors without knowing whether any followˆup action was taken. When asked why she did not notify the nursing/management staff immediately after Residents #2, #3 and #4 returned inside with their smoking supplies this morning, she replied t

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility and resident records, staff interviews, a review of the facility's policies titled Quality Assessment and Performance Improvement (QAPI) Policy and Risk Management, and a review of QAPI meeting documentation, the facility failed to have an effective QAPI process that used adverse event data and safety information related to smoking and oxygen use, to identify a Root Cause Analysis (RCA) and develop relevant performance improvement activities to prevent similar future events. Resident #1, with a known history of smoking in his room while using oxygen, was again found smoking in his room while using oxygen. His nasal cannula ignited and he sustained second-degree facial burns and respiratory distress requiring emergent transport to an acute care hospital burn unit for treatment. Resident #1 and three other residents (#2, #3 and #4) were known to keep cigarettes and lighters on their person or in their rooms, and two of the four (Residents #1 and #2) were oxygen-dependent and were known to smoke in their rooms. Despite direct observations by staff and leadership, as well as leadership's awareness of these residents' dangerous behavior, the facility failed to develop measures needed to ensure the safety and protection of these and other residents at risk. The facility had 45 residents who smoked at the time of the survey. Immediate Jeopardy (IJ) at a scope and severity of L (widespread) was identified at 10:45 AM on 3/30/26.On 2/27/26, Immediate Jeopardy began.On 4/1/26 at 5:45 PM, the Administrator was notified of the IJ determination. IJ templates were provided, and Immediate Jeopardy was ongoing as of the survey exit on 4/1/26.The findings include:Cross reference F600, F609, F689, and F835During a facility tour on 3/30/26 at 9:58 AM, three residents were observed sitting in their wheelchairs inside the facility near the designated smoking area door waiting for staff to open the door for their scheduled smoking period at 10:00 AM. Certified Nursing Assistant (CNA) A, assigned to supervise the residents who smoked, opened the door leading to the designated smoking area (back porch) at 10:00 AM. CNA A did not provide the three residents with smoking materials; all three residents had cigarettes and lighters already in their possession. At 10:16 AM, all three residents left the designated smoking area and re-entered the facility without providing their smoking materials to CNA A for storage in the smoking area locked cart.Another tour of the facility on 3/30/26 at 10:45 AM revealed that the same three residents who had not relinquished their smoking materials to CNA A in the designated smoking area at 10:16 AM were assigned to rooms [ROOM NUMBERS]. room [ROOM NUMBER] (Residents #2 and #4) and room [ROOM NUMBER] (Resident #3) had Oxygen in Use/No Smoking signs posted on the door frames outside of the rooms.1.A review of Resident #1's medical record revealed that he was admitted to the facility on [DATE], was transferred to an acute care hospital on 2/27/26 and was re-admitted on [DATE]. His diagnoses included chronic obstructive pulmonary disease (COPD - constriction of the airways and difficulty breathing) with acute exacerbation (sudden, severe worsening); alcohol abuse; noncompliance with other medical treatment and regimen; difficulty in walking; dysphagia (difficulty swallowing); anxiety disorder and mood disorder.A nursing note authored by Registered Nurse (RN) E on 2/27/26 revealed that she heard Certified Nursing Assistant (CNA) B scream that Resident #1's oxygen tubing was on fire and entered the room to find the nasal cannula tubing burning, a cigarette on the floor, and smoke spreading throughout the room. The nurse paged a Code Red (an intercom announcement indicating a fire or smoke emergency alerting staff to activate fire safety protocols) and obtained a fire extinguisher while another staff member called 911. RN E then provided care to the resident.A Change in Condition form, completed by RN F on 2/27/26 at 10:35 PM, noted that Resident #1's oxygen tubing caught fire while he was smoking in his room, resulting in burns to his nose and right cheek with pain rated at a 4 on a scale of zero through 10 with 10 being the worst possible pain. He was documented with increased confusion, general weakness, dizziness, unsteadiness, and labored, rapid breathing. His oxygen saturation was 98% on room air, he (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	was a full code, and primary care was notified on 2/27/26 at 10:42 PM with orders to send him to the emergency room. Emergency Medical Services (EMS)/911 was called, and family was notified.A review of the resident's active physician's orders revealed that on 2/28/26, a physician's order was placed to send the resident to the Emergency Department (ED) for evaluation and treatment.A review of the February 2026 medication administration record (MAR) and treatment administration record (TAR) revealed that Resident #1's oxygen was delivered continuously via nasal cannula at 2 LPM according to the nurses' documentation of task completion from 2/1/26 - 2/27/26. The MAR/TAR included documentation of Resident #1's hospital/ED (Emergency Department) transfer on 2/28/26 at 12:54 AM.A review of hospital records revealed that on 2/27/26, Resident #1, diagnosed with Chronic Obstructive Pulmonary Disease (COPD) and receiving oxygen via a nasal cannula at the nursing home, lit a cigarette and sustained superficial partialˆthickness burns of his face with a concern for inhalation injury. He required intubation during transport for airway protection and was accepted by the trauma/burn team. On 2/28/26 at 4:59 AM, he was documented as intubated and sedated, with soot in the nares (nostrils) and oropharynx (throat), and superficial partialˆthickness burns to the bridge of the nose and right cheek. An interview was conducted with Resident #1 on 3/30/26 at 9:51 AM. He was observed lying in bed, awake, wearing his nasal cannula with oxygen flowing at 3 liters per minute (LPM). When he was asked about his 2/27/26 incident, he stated he smoked a cigarette in his room while wearing oxygen via nasal cannula, the cannula ignited, and he sustained burns to his face that required emergent transport to the hospital. When asked if he had been educated about the facility's smoking policy prior to the event, he stated he had received education, but he was a 72ˆyearˆold man and would smoke whenever he wanted to. When asked whether he kept his cigarettes and lighter in his room or provided them to the certified nursing assistant (CNA) supervising smokers in the designated smoking area, he stated he did not give his supplies to staff but always kept all of his smoking materials with him. When asked if he had smoked in his room prior to the 2/27/26 incident, he stated he had previously smoked in the bathroom of his room (room [ROOM NUMBER]), and in room [ROOM NUMBER]. When asked if nursing staff rounded frequently to check on/supervise the residents in his room, he stated he barely saw anyone come into his room prior to the incident. When asked if he continued to smoke after the 2/27/26 incident, he stated he quit smoking after that event. When he was asked how he obtained his cigarettes and lighters, he stated he would ask other residents to purchase cigarettes and lighters for him or have a personal friend bring them to him. When asked if he informed staff that he had cigarettes and a lighter on his person, he stated he never did. When asked if he knew he was violating the facility's policy, he stated he was aware but did not care. When asked if staff had requested that he relinquish his smoking supplies to them for proper storage, he stated he never gave them anything.Further review of Resident #1's medical record revealed the following nursing notes:A nursing note dated 9/25/24 at 2:24 PM revealed that Resident #1 was observed smoking cigarettes in his room while connected to his oxygen concentrator. The nurse provided education and informed the resident that smoking in the room, especially while on oxygen, was prohibited and posed a serious safety risk to him and other residents. The nurse then contacted law enforcement to assist with the situation. There was no documented evidence verifying that the nurse requested that the resident relinquish his smoking materials or that she confiscated them.A nursing behavior note dated 9/25/24 at 2:59 PM revealed that the writer noticed a smell of cigarette smoke. She went inside Resident #1's room and found him smoking with his nasal cannula on and oxygen flowing. Resident #1 was asked to extinguish his cigarette, and he put it into a beer can between his feet. Seven beer cans were also found in a trash bag under his bedside table. When staff requested that he relinquish his cigarettes and beer, he refused, became belligerent, and insisted he paid for them. The unit manager and the Director of Nursing (DON) were notified, and law enforcement was called. When law enforcement arrived, the resident denied smoking in the building, stated he did not care about others' safety, and insisted he would keep his cigarettes. He ultimately surrendered five cigarettes from a carton to the officer, who (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Westside Oaks Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2061 Hyde Park Rd Jacksonville, FL 32210	

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