STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185455	A. Building B. Wing	04/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valhalla Post Acute	300 Shelby Station Drive Louisville, KY 40245

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm 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** 44396 Based on observation, interview, and review of the facility's policy, it was determined the facility failed to provide a safe environment for residents. One sampled resident (Resident (R) 57) was not assessed for smoking, in accordance with facility policy. This non-smoking facility failed to ensure that incendiary devices (lighters) were not accessible to R57, who was involved in two separate instances of fire in his room. R57 was found to be in possession of cigarettes and a lighter after a fire in his bathroom on 04/15/2024. The following day, 04/16/2024, R57 had a fire in his closet. This failure to assure lighters were secured had the potential to affect six additional sampled residents (R40, R503, R14, R87, R504, and R506) as well as up to 58 residents who resided on one of four units (English Oak Terrace (EOT)) which was evacuated due to the fires, out of a total census of 150 residents. The findings include: Review of the facility's policy, Smoking Policy - Residents, revised 02/28/2024, revealed that prior to, and upon admission, residents were informed of the facility's policy to remain a smoke free environment. Per the policy, smoking was not permitted on facility property and smoking was not allowed inside the facility under any circumstances. Continued review of the policy revealed the resident's smoking status was evaluated upon admission. Per the policy, the facility maintained the right to confiscate smoking items found in violation of their smoking policies. The policy did not detail storing residents' lighters or other smoking paraphernalia. Review of the facility's undated Prohibited Items document, included in the facility's Welcome Packet, revealed that, to keep residents safe and to stay in compliance with State and Federal regulations, the following items are prohibited in patient rooms or patient care areas any item that produced open flames including lighters and matches, also tobacco products (including smokeless). 1. Review of R57's history and physical (H & P) from the local hospital, dated 11/01/2022, revealed he was admitted to the Intensive Care Unit (ICU) after he underwent a thrombectomy (procedure to remove blood clots from the blood vessel) secondary to occlusion in the M1 (proximal) section of the middle cerebral artery. Further review of the H & P revealed R57 was a smoker. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R57's Admission Record revealed the facility admitted him to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis (paralysis on one side of the body) following a cerebral infarction affecting the right dominant side, aphasia (a language disorder caused by damage to the brain) following cerebral infarction, chronic obstructive pulmonary disease (COPD) and noncompliance with other medical treatment and regimen due to unspecified reason. Review of R57's Admission Agreement, originally dated 11/15/2022, and signed with the resident's name but identified as his brother and responsible party, on 11/25/2022, revealed the tobacco policy was such that the resident and resident's guests agreed to follow facility rules and regulations regarding smoking within the facility and may smoke only in designated areas, if any, under appropriate staff supervision. Review of the admission Minimum Data Set (MDS), with a date of 11/23/2022, included results of his Brief Interview for Mental Status (BIMS). Review of the BIMS revealed a score of 0/15, indicating severe cognitive impairment. Review of a quarterly MDS assessment, dated 12/16/2023, revealed a BIMS score of 10/15, indicating moderate cognitive impairment. Review of the most recent MDS, a quarterly assessment dated [DATE], revealed no BIMS summary score was calculated, instead, a Staff Assessment for Mental Status documented the resident's short- and long-term memory was okay, that he could recall current season and the location of own room and that he was independent in decisions regarding tasks of daily life with no acute onset mental status change. The 03/17/2024 MDS documented no behaviors directed towards himself or others. However, per Progress Notes, the resident did display behaviors after this MDS assessment, including cornering a staff member and swinging his first at her (03/28/2024), purposely running his wheelchair into staff, and attempting to leave the building on 04/02/2024. Review of R57's complete history of clinical assessments since admission revealed no Smoking Assessment was completed, per facility policy, until 04/17/2024, after the resident sustained two fires in his room (on 04/15/2024 and 04/16/2024.) Review of the Smoking Assessment, dated 04/17/2024, revealed R57 smoked one - two times per day at various times. Further review revealed R57 had no cognitive loss, visual deficits, dexterity problems and could light his own cigarette but the assessment did not indicate if the resident could smoke with, or without, supervision. In an interview with the Admissions Director on 04/20/2024 at 9:20 AM, she was not aware of when a smoking assessment was completed for a resident. During interview with Licensed Practical Nurse (LPN)16 on 04/17/2024 at 12:54 PM, she stated a smoking assessment was part of the admission assessment, and there was no recurrent smoking assessment completed after the admission assessment. After failure to assess R57 for smoking, the resident was involved in two separate fires in his room. Review of an Initial Report to the State Survey Agency, (SSA) dated 04/15/2024, revealed that there was a fire at the facility that day. Per the report, staff smelled cigarette smoke and went into R57's room. R57 was coming out of the bathroom, going back to his bed. Staff found a lighter next to the resident's bed. Staff were interviewing the resident about smoking, which he denied, when they noticed smoke coming from the bathroom at approximately 11:52 AM. Staff evacuated the room, extinguished the fire, and advised the Administrator of the incident. The hallway was evacuated, and the fire department arrived. R57 continued to deny smoking and was placed on 15-minute checks. Both a cigarette and a lighter were found in the resident's room after the event. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of the facility lobby on 04/16/2024 at 12:08 PM revealed an alarm sounding, which proved to be a genuine fire alarm and not a drill. The survey team exited the conference room and observed that staff evacuated 16 residents who were present on the EOT unit where the fire started, in about seven minutes. There was a copious amount of smoke in the hall when the door was opened to allow evacuation of the residents from the unit to the lobby area. Observation of the EOT unit on 04/16/2024 at 1:42 PM revealed R57's room, a semiprivate room, had sustained a fire in the closet, as evidenced by fire extinguisher residue and water as well as blackened dry wall. There was copious amounts of water in the closet, R57's room, hallway, and surrounding resident rooms, as well as saturated ceiling tiles that had fallen to the floor, plus particles that appeared to be insulation from above the tiles or residue from the sprinklers. ServePro, a business specializing in fire and water damage restoration, was already in the facility, and had begun water extraction. Review of R57's record revealed he was transferred to the hospital on 04/16/2024, after the second fire, for evaluation. Review of the hospital records, dated 04/19/2024, revealed the resident suffered from severe expressive aphasia and only responded yes or no to closed ended questions during interview. Upon evaluation, R57 indicated he did not set the fire intentionally, knew the facility was nonsmoking, and that he knew it was wrong to dissipate [sic] the rules. During interview with the Social Services Assistant (SSA) on 04/18/2024 at 8:22 AM, he stated he usually rounds on R57 and his roommate to help with managing behaviors. He stated he was in the hall of EOT on 04/15/2024 around noon and smelled smoke. He stated he alerted the Unit Manager (UM) who dispatched a Certified Nurse Aide (CNA) to accompany him to locate the source of the smoke smell. He stated they went to R57's room and could smell smoke but could not determine the source. He stated that R57, who was present in the room at this time, denied he was smoking. Upon the UM's entrance, they searched surfaces, looking for smoking materials. The SSA stated he opened the bathroom door and smoke was coming from the linen closet, specifically from a hamper that contained clothing items. He stated he kicked it into the shower and turned on the water to extinguish the fire. He further stated nurses evacuated the residents while he stayed in the bathroom until the fire department came. During the interview on 04/18/2024 at 8:22 AM, the Social Services Assistant stated that after the fire on 04/15/2024, R57 stayed at the nurses' desk in the EOT most of the day after everything was resolved, and the resident was placed on 15-minute checks. The SSA stated that on the following day, 04/16/2024 at approximately 12:05 PM, he was doing rounds on EOT and went to talk to the UM about another resident. He stated another staff member then alerted him to a smell and he went to check its source. He went into R57's room with the UM, and asked R57 if he was smoking, which he denied loudly. The SSA stated they then turned around and observed smoke coming from the closet. The SSA stated they shouted for an alarm to be sounded and for a fire extinguisher, which was brought quickly. He stated he opened the door and used the extinguisher to put out the flame. Subsequently, the SSA closed the door, the Administrator took R57 out of the room while he (the SSA) carried the roommate out, followed by evacuation for the rest of the unit. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview with the EOT UM on 04/17/2024 at 4:45 PM, she stated the SSA was coming down the hall on 04/15/2024, smelled smoke and went in R57's room. The UM stated the SSA looked around the room, saw a lighter and confiscated it. The UM stated she came to the room when the SSA brought the lighter. They both smelled cigarette smoke and thought something was on fire. The UM confirmed that the SSA opened the bathroom, found a trash can on fire in the bathroom closet which he kicked to the shower, and then extinguished the fire with water. The UM stated that in response, the unit was completely evacuated and R57 was placed on 15-minute checks. During continued interview, the UM stated the fire situation on 04/16/2024 was identical to the previous day, with the SSA in hallway, who then came for the UM and went in R57's room. She stated they asked R57 if he was smoking, and he denied it. When exiting the room, the UM stated she told the SSA she smelled something burning, and both sniffed for the location. She stated the SSA opened the closet door and fire whooshed out, such that they had to jump back. The UM stated they yelled for the fire alarm and a fire extinguisher. She confirmed the SSA put the fire out, and residents were evacuated. Further interview with the UM revealed she was told R140 may have provided a lighter and cigarette to R57 but there was no way to confirm this, and they did not really know where the lighters were coming from. During telephone interview with Certified Nursing Assistant (CNA) 37 on 04/19/2024 at 5:09 PM, she stated she knew R140 and R14 smoked and believed R57 used to smoke, saying that R57 went out with others in the past. She stated she was aware that R140 kept a lighter in their jacket pocket, and that it was found when she or others picked up the jacket and it fell from the pocket. CNA37 stated she confiscated this lighter when she found it and reported it but was not sure if R140 continued carrying a lighter and was not sure of the date this incident had occurred. She stated problems with smoking started when several residents transferred from a facility that closed, and many of those residents from the closed facility smoked and just continued to do it at this facility. She stated at least two residents were caught smoking in their room, though neither was currently in the facility. CNA37 stated it was kind of a chain reaction after residents who moved in smoked, as other residents now wanted to smoke as well. CNA37 stated that those residents who could sign out independently, could go off property and smoke. She stated lighters were not supposed to be on property, that R140 was supposed to keep their lighter and cigarettes at the nurses' desk, and staff were expected to confiscate any smoking materials found and report it. After the fire on 04/15/2024, she stated R57 indicated R140 had given him the cigarette and lighter. She further stated that, upon questioning R140, he did not deny giving R57 a lighter, and stated Well, they should have let him go out to smoke. During interview with the SSA on 04/18/2024 at 8:22 AM. the SSA identified additional smokers in the facility (besides R140) included R503, R14, R87, R504, and R506. He further stated R140 was no longer in the facility at this time and was not available for interview. a. During interview with R503 on 04/17/2024 at 3:28 PM, he stated he smokes and kept his cigarettes and lighter locked up in his bedside table drawer. During interview with the EOG UM on 04/17/2024 at 3:42 PM, she acknowledged R503 was able to go out and smoke, away from the building. She stated she understood cigarettes and lighters were kept at the front desk by the receptionist. In further interview, she stated she was unaware that the resident was keeping a lighter or cigarettes in his room and indicated the need to follow up. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In interview with the SSA on 04/18/2024 at 8:22 AM, the SSA stated he confiscated a lighter from R503 the previous afternoon. He stated he had taken R503 to an appointment yesterday and R503 had smoked while they were waiting. He stated he had observed that R503 had cigarettes and two lighters but since R503 was independent in his wheelchair, he did not escort R503 to his room. When he passed the desk, he noted the receptionist had the cigarettes and only one lighter, thus came to R503's room. He stated he told R503 he knew he had the lighter and R503 gave it up. b. Interview with R504 on 04/19/2024 at 5:25 PM, revealed that prior to the two fire events, he kept his cigarettes and lighter in his top drawer and had no key to keep these items secured. He stated he believed that staff knew he smoked, as some of the staff had seen him smoke off the property and nobody asked him for his cigarette or lighter when he returned to the building. He voiced irritation because, after the fire, staff searched his room. During an additional interview with R504 on 04/20/2024 at 9:31 AM, he stated his lighter and cigarettes were not confiscated until after the second fire. c. During interview with R14 on 04/20/2024 at 9:25 AM, he stated before the fire he kept his lighter and cigarettes in his room, and believed staff knew he smoked. He stated his lighter and cigarettes were confiscated after the fire but was not sure whether it was after the first or second fire. d. An attempted interview with R87 on 04/20/2024 at 9:36 AM, was unsuccessful, as when the survey team asked about smoking, he shut his eyes tightly and would not answer questions. e. During interview with R506 on 04/20/2024 at 10:26 AM, he stated that when he smoked, he got a light from one of the other residents who smoked. During interview with LPN16 on 04/17/2024 at 12:54 PM, she stated the facility was strictly non-smoking, but lately they have had residents who go off premises to smoke. She stated she did not know where smoking materials were stored. Observation on 04/17/2024 at 3:52 PM revealed Main Entrance Receptionist 1 demonstrated how she secured smoking materials, including lighters, in a locked box with a key. The lockbox currently contained two packs of cigarettes, each with a lighter as well as a vape. During interview at the same time, the receptionist she stated they used to keep lighters/smoking materials in this manner but got away from this process and was not sure why. When asked when the facility restarted this process of keeping all smoking materials, including lighters, locked up, the receptionist whispered Today, (after the initiation of the survey and the two fires in the facility). In an interview with Main Entrance Receptionist 2 (who worked on the weekends) on 04/20/2024 at 11:10 AM, he stated that to smoke, the resident required an escort off the property, had a sign in/out on their personal sheet, he then unlocked the lock box and provided the resident with cigarettes and one lighter. He then double checked the checklist and ensured everything was completed prior to the resident exiting the building. The same process was followed when the resident returned. The receptionist stated when his shift was over at 8:00 PM, the lock box was placed in another locked cabinet for the night and the key was placed in a secret location. He said he followed this process for the six months he worked at the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview with the Social Services Director on 04/19/2024 at 1:04 PM, she stated she has worked at the facility since 2018 and has always been under the impression this was a smoke free facility. She stated there were policies for smokers, such as a resident can only smoke if they leave the campus, and the Nurse Practitioner (APRN) had to sign off for it. She stated they have to keep the cigarettes/lighter at the front desk but have not always had to do this. In an interview with the Admissions Director on 04/20/2024 at 9:20 AM, she stated her assistant met with potential residents prior to admission and discussed all the requirements for admission. She said the residents/family were informed at that time that the facility was nonsmoking. She said a Welcome Packet was left in the resident's room and a CNA was supposed to go to the room and orient the resident on their first day. The Admissions Director said at this time, the resident was informed of prohibited items (which included lighters). She stated that when residents were identified as smokers, they were told they had to leave their cigarettes and lighter at the front desk. The items were placed in a bag with the resident's name on it. She stated this process was for cigarettes and all other tobacco related products, such as lighters, matches, and vapes. The Admissions Director stated there would be no way for staff to know if a resident had a lighter hidden in the room, unless the resident left it out in plain sight, dropped it or it fell out of the resident's pocket. In an interview with CNA17 on 04/20/2024 at 11:00 AM, she was presented a welcome packet and asked to walk through it as if she was welcoming a resident for the first time. She went through each page and explained what she said to a new resident; however, she skipped the page with prohibited items (including lighters) listed on it. When asked about the prohibited items section of the packet. she said she thought the nurses usually went over that part of the packet with the resident. CNA17 stated she had not been educated on welcoming new residents. In an interview with CNA22 on 04/20/2024 at 11:20 AM, she was conducting a new admission. The CNA said she was not aware of the welcome process, and had not seen the packet, with the prohibited item list, before. CNA22 did not recall the welcome process being discussed in orientation. During interview with the Assistant Director of Nursing (ADON) on 04/19/2024 at 4:14 PM, she stated they had not had issues until the facility received residents who transferred here after a building closure. She stated that with the arrival of the new residents, they had a lot of noncompliance with smoking, and a lot of the residents already in the building were questioning why others could smoke, so when socializing outside, they might get cigarettes from others. The ADON stated they now have a log where there was an effort to track smoking materials and residents were now expected to keep materials at the front desk. However, she acknowledged they did not have a formal method to track possession of smoking materials, including lighters, as of 04/15/2024 when the first fire occurred. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview with the Director of Nursing (DON) on 04/20/2024 at 11:53 AM, she stated when she came to this job almost a year ago, it was a non-smoking campus. She stated that if a resident smoked, he or she would have to go off the campus. The DON stated the resident would have to be assessed to be safe to leave the property independently, and then, if they smoked when they go off the property, that was their right. She stated that when a resident who signed out returned, they had to sign back into the facility, but the facility did not ask everybody if they were smoking or if they have prohibited items such as a lighter. The DON stated the expectation was if staff observed something different with a resident, such as appearing impaired, or if a resident smelled like cigarette smoke, they must report it to the DON. She stated that if they did ask residents if they had lighters and/or cigarettes or other tobacco products, they had to depend on the residents to be honest that they did not have any prohibited items in their room or on their body. The DON stated they did not place R57 on one-to-one supervision after the first fire because his room had been searched and no other lighter (besides the one the SSA confiscated) was found. The DON further stated residents were notified of prohibited items at admission from the admissions staff, and that the welcome packet in their rooms included the list of prohibited items. During this interview, the DON added that the administrative staff do Angel Rounds, on a weekly basis where staff go to each resident's room and assess a variety of issues. During these rounds, the DON stated, staff also look for prohibited items. However, review of the Guardian Angel Rounds form used during these checks revealed that it did not indicate that staff were to check for prohibited items, including lighters. In an interview with the Administrator on 04/20/2024 at 1:15 PM, he indicated there was a gas station across the parking lot, where residents who went off the property would have the ability to buy smoking materials, including lighters. He stated the facility had a system in place for each resident who was identified as a smoker and they were to sign their cigarettes and lighter in and out each time they went out to smoke. The Administrator stated the facility would have no way of knowing if a resident purchased another lighter at the gas station, other than having the receptionist asked if they had any other lighters. If a resident said no, they had to take them at their word unless there was a reason not to. The Administrator said residents had rights and could not be searched without their permission. The Administrator stated he worked with the management team and staff to ensure no lighters were getting through by checking rooms for any obvious signs of smoking and had not found any. 43694