

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/22/2025
NAME OF PROVIDER OR SUPPLIER  Beaconshire Nursing Centre		STREET ADDRESS, CITY, STATE, ZIP CODE  21630 Hessel Detroit, MI 48219	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47964</p> <p>This citation pertains to intake MI00149479.</p> <p>Based on observation, interview, and record review, the facility failed to ensure staff reported an injury related to fire to the abuse coordinator for one resident (R401) out of four residents reviewed for accidents, resulting in an unreported incident of potential neglect.</p> <p>Findings include:</p> <p>On 1/13/2025 at 11:34 AM the State Agency received a complaint that on 11/10/2025 R401 lit a cigarette while on oxygen and lit his face on fire.</p> <p>On 1/15/2025 at 10:50 AM R401's guardian A was interviewed and said a staff member from the facility called to notify him on 1/11/25 or 1/12/25 that R401 lit his face on fire smoking again in is bathroom and was at hospital C.</p> <p>On 1/21/24 at 2:00 PM R401 was interviewed at Hospital L. R401 was observed as an African American male with dark colored skin. R401's tip of nose was pink in color missing skin, top lip pink in color missing skin, bottom lip was scabbed. Both lips appeared swollen. R401's right cheek appeared pink in color missing skin. R401 knew he was at hospital L, his name and the date. When asked what happened on 1/10/25 R401 replied I lit a cigarette in my bathroom while wearing my oxygen and lit my face on fire. I told everyone that I fell and injured my face, but they knew what happened. I didn't fall. I didn't want the staff to get in trouble for what I did. I had my own cigarette and lighter from earlier in the day. The sitter didn't take back my cigarette and lighter from the earlier smoke break. The facility called EMS the next day after I kept asking them to send me to the hospital because my face hurt from the burns, and I couldn't breathe good.</p> <p>Record review of R401's Electronic Health Record (EHR) revealed the resident admitted to the facility on [DATE], with most recent readmission on 1/19/2025, with diagnoses which included subdural hemorrhage, chronic obstructive pulmonary disease (COPD), schizophrenia, adjustment disorder with mixed anxiety, and depressed mood.</p> <p>Review of the Minimum Data Set (MDS) dated [DATE] for R401 revealed a Brief Interview for Mental Status (BIMS) of 10/15 which indicated moderate cognitive impairment and partial/moderate assistance for transfers.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility progress note dated 1/10/2025 at 10:30 PM revealed, Writer observed injury when rounding on resident. Resident stated he fell in the bathroom. Writer assessed resident vital signs as follow 148/74 pulse 98, respirations 18, oxygen saturation 96% via nasal cannula. Temperature 97.8. Wound care provided resident tolerated well.</p> <p>Review of the facility progress note dated 1/11/2025 at 13:33 (1:33 PM) revealed, new order for stat x-ray of the optic and nasal bone to rule out a fracture 2 views per doctor.</p> <p>Review of the facility progress note dated 1/11/25 at 15:08 (3:08 PM) revealed, resident requested to transfer to the hospital physician and guardian notified.</p> <p>Review of the facility progress note dated 1/11/25 at 20:42 revealed, resident is transferred to (hospital B) at 7:15PM as per instructions provided by outgoing nurse and doctor, writer received recent Xray result, xray report stated the orbit demonstrate no acute fracture. No joint dislocation. Unremarkable soft tissues, medical doctor and Guardian A are notified.</p> <p>Review of the Prehospital Care Report by Emergency Medical Services (EMS) dated 1/11/25 revealed, EMS responded to priority 2 to facility for difficulty breathing. EMS arrived on location with no incident. EMS entered the building and located the patient room. EMS received report from the nursing. EMS entered the room and made patient contact. Patient was found standing using an oxygen concentrator as a brace. Patient was hooked up on oxygen flowing at 8LPM via nasal cannula. Patient presented baseline with no current complaints of pain. Patient had burn marks on his face from the prior night, nursing home staff informed EMS that the burns were from a cigarette from the prior night. EMS began transport to [NAME] Grace Hospital emergency room (ER) priority 1 for facial burns. EMS swapped the patients nasal cannula for a non-rebreather mask due to patient complaint of difficulty breathing. EMS arrived at [NAME] Grace ER with no incident. Patient arrived at Destination Date/Time 2025-01-11 20:28:24.</p> <p>Record review of the Hospital B emergency Treatment note dated 1/11/2025 at 21:10 revealed, R401 with a history of COPD on home oxygen presents emergency department facial burn. Patient states last night (1/10/25) he was on his nasal canula oxygen and attempted to smoke a cigarette causing the nasal cannula to light on fire burning his face. Second degree burns to upper and lower lip, right face, nose. Periorbital (around eye) swelling and edema of the lips. Patient will require transfer to a burn center. Disposition transferred to (Hospital C.)</p> <p>Record review of the Hospital C progress note dated 1/13/25 revealed, R401 presents to the emergency department as a transfer after a facial burn sustained while smoking on home oxygen. Sustained ~1.5% partial thickness burns to right side of face. admitted to burn service. Integumentary: warm, dry ~1.5 % partial thickness burns to right side of face. Lips swollen with some partial thickness burns.</p> <p>On 1/15/25 at 2:55 PM Licensed Practical Nurse (LPN) D was interviewed and said she was called to R401's room on 1/10/25 by Sitter E. LPN D stated, R401 said he fell in the bathroom. His face appeared red. He was wearing his oxygen when I arrived, the oxygen tubing was intact. When asked did R401 have facial burns LPN D replied The only thing I saw was redness to his face.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/15/25 at 3:45 PM LPN F was interviewed and said that on 1/11/15 R401 requested to go to the hospital. When asked did R401 have facial burns LPN F replied, R401 told me he fell the night before (1/10/25) I saw that his face was swollen.</p> <p>On 1/15/25 at 4:00 PM the facility's Chief Operating Officer (COO) I provided Hospital C progress notes and acknowledged R401 was hospitalized for facial burns. When queried, COO I reported being unaware of R401 setting his face on fire while on oxygen, in the bathroom.</p> <p>On 1/15/25 at 4:50 PM Sitter E was interviewed by phone and said that she worked with R401 on 1/10/24 from 3PM to 11PM. Around 10:30 PM R401 went to the bathroom by himself and yelled. He was wearing his oxygen. He said he fell . I called for nurse LPN D. Sitter E said she did not smell smoke, nor did she see any burns on R401's face. Sitter E said she took R401 out to smoke on 1/10/25 around 8:00 PM by herself. Sitter E abruptly ended the interview and did not respond to further attempts for an interview.</p> <p>On 1/16/25 at 2:15 PM and 3:33 PM Sitter E was called for an interview. Left messages with no return call.</p> <p>On 1/16/25 at 10:00 AM the Nursing Home Administrator/Abuse Coordinator (NHA) was interviewed and said she was told R401 fell and injured his face which is the reason R401 was sent to the hospital on 1/11/25.</p> <p>On 1/16/25 at 10:54 AM LPN G was interviewed and said she was the nurse supervisor on 1/10/25 and on 1/11/25. On 1/11/25 she put in a stat (immediate) order for an Xray of R401's face due to his complaints of pain. LPN G said when she saw R401 on 1/11/25 R401 had swelling to his right eye and He had grease on his face like Vaseline.</p> <p>On 1/16/25 at 12:07 PM LPN H was interviewed and said that he observed EMS pick up R401 on 1/11/25 to take him to the hospital. LPN H said he assisted EMS for the hospital transfer. LPN H stated, R401 did not have any open wounds on his face when he was transported to the hospital but R401's face was swollen.</p> <p>On 1/16/25 at 2:50 PM Certified Nursing Assistant (CNA) J was interviewed and said that she worked with R401 on 1/11/25 day shift from 7AM to 3PM. CNA J said she saw R401 at approximately 1:30 PM on 1/11/25. CNA J stated, I thought R401 went to the hospital because his face it looked bad. He was drooling, he couldn't close his mouth. His face was pink including his lips. Everything was pink around his oxygen canula.</p> <p>On 1/16/25 at 3:49 PM the Director of Nursing (DON) and the NHA/Abuse Coordinator were interviewed. The DON said R401 was sent to the hospital following his fall per the resident request. The DON said R401 experienced combustion in August 2024, smoking while on oxygen and set his face on fire. The DON acknowledged R401 was admitted to the hospital with facial burns. During the interview the DON and the NHA/Abuse Coordinator reported not being aware of any incidents of fire prior to R401 being admitted to the hospital for facial burns.</p> <p>Review of R401's EHR for January 2025 did not reveal any documentation of a facial burn or an acute care transfer sheet (to be completed by facility nursing staff) completed for 1/11/25.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R401's care plan revealed Focus: I am a smoker, and I am aware that I need to follow the smoking policy. I have violated the smoking policy, and it resulted in me being injured. Date initiated 8/30/24. Goal: I will follow the smoking policy. Thru next review date. Date initiated 8/30/24. Target date 3/3/25. Interventions: I am aware that a lighter nor cigarettes can be keep on my person or in my room or possession. Date initiated 10/3/24. I am aware that I can only smoke at smoking times with supervision. Date initiated 10/10/24. I am aware that I will be offered a smoking patch or smoking gum if I violated the policy. Date initiated 10/3/24. I require a sitter at my bedside for safety date initiated 11/27/24. I understand if I violated the smoking policy that I will lose my smoking privileges for 7 days or I maybe involuntary discharge from the facility. Date initiated 10/3/24.</p> <p>Further review of R401's care plan revealed Focus: The resident has oxygen therapy related to a diagnosis of COPD as evidenced by low oxygen saturation and shortness of breath. Date initiated 8/21/24. Goal I will be complaint with oxygen therapy. My oxygen saturation will be between 95 and 100 percent. Date initiated 8/21/24 Target date 3/3/25. Intervention: I was educated about the importance of not using flammables around oxygen therapy. Date initiated 8/30/24.</p> <p>On 1/21/25 at 12:30 PM Medical Doctor (MD) K was interviewed and said R401 had been hospitalized for facial burns. When asked how he was informed of R401's hospitalization MD K replied I was told by a nurse from the facility that R401 was in the hospital with facial burns.</p> <p>Review of the facility policy titled Abuse, Neglect and Exploitation date reviewed/revised revealed in part: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Abuse includes the deprivation by an individual, including caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be indication of noncompliance with Federal requirements related to mistreatment, exploitation, neglect, or abuse including injuries of unknown source. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies(e.g. law enforcement when applicable) within specified timeframes: a Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. 2 Assuring that reporters are free from retaliation or reprisal; 5. Taking all necessary actions as a result if the investigation, which may include, but are not limited to the following: a. Analyzing the occurrence to determine why abuse, neglect, misappropriation of resident property of exploitation occurred, and what changes are needed to prevent further occurrences.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47964</p> <p>This citation pertains to intake MI00149479.</p> <p>Based on observation, interview, and record review, the facility failed to provide adequate supervision for one resident (R401) on oxygen with a known history of unsupervised smoking and noncompliance with smoking policy out of four residents reviewed for safety with smoking, which led to a fire resulting in a 2nd degree facial burns((an injury that damages the outer layer of skin (epidermis) and part of the underlying layer(dermis)) and hospitalization in the burn unit.</p> <p>The Immediate Jeopardy began on 1/10/25 when an untrained facility staff (sitter) failed to properly supervise R401 during a smoke break leading to the R401 obtaining a lighter and cigarette. Later, R401 (while inhaling oxygen through a nasal canula) attempted to smoke in his bathroom unsupervised and lit his face on fire. The Nursing Home Administrator (NHA) was notified of the Immediate Jeopardy (IJ) on 1/22/25 at 3:50 PM. The IJ was removed on 1/22/25, but noncompliance remains at a potential for harm due to sustained compliance that has not been verified by the State Agency.</p> <p>Findings include:</p> <p>On 1/13/2025 at 11:34 AM the State Agency received a complaint that on 11/10/2025 R401 lit a cigarette while on oxygen and lit his face on fire.</p> <p>Record review of R401's Electronic Health Record (EHR) revealed the resident admitted to facility on 3/6/2024 with a most recent readmission on 1/19/2025 with diagnoses which included subdural hemorrhage, chronic obstructive pulmonary disease (COPD), schizophrenia, adjustment disorder with mixed anxiety and depressed mood.</p> <p>Review of the Minimum Data Set (MDS) dated [DATE] for R401 revealed a Brief Interview for Mental Status (BIMS) of 10/15 which indicated moderate cognitive impairment and partial/moderate assistance for transfers.</p> <p>On 1/15/2025 at 10:50 AM R401's guardian A was interviewed and said a staff member from the facility called to notify him on 1/11/25 or 1/12/25 that R401 lit his face on fire smoking again in his bathroom and was at hospital C. R401 had previously</p> <p>Review of the facility progress note dated 1/10/2025 at 10:30 PM revealed, writer observed injury when rounding on resident. Resident stated he fell in the bathroom. Writer assessed resident vital signs as follow 148/74 pulse 98, respirations 18, oxygen saturation 96% via nasal cannula. Temperature 97.8. Wound care provided resident tolerated well.</p> <p>Review of the facility progress note dated 1/11/2025 at 13:33 revealed, new order for stat x-ray of the optic and nasal bone to rule out a fracture 2 views per doctor.</p> <p>Review of the facility progress note dated 1/11/25 at 15:08 revealed, resident requested to transfer to the hospital physician and guardian notified.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the facility progress note dated 1/11/25 20:42 revealed, resident is transferred to (Hospital B) at 7:15PM as per instructions provided by outgoing nurse and doctor, writer received recent xray result, xray report stated the orbit demonstrate no acute fracture. No joint dislocation. Unremarkable soft tissues.</p> <p>Record review of the hospital B emergency Treatment note dated 1/11/2025 at 21:10 revealed, (R401) with a history of COPD on home oxygen presents emergency department facial burn. Patient states last night (1/10/25) he was on his nasal canula oxygen and attempted to smoke a cigarette causing the nasal cannula to light on fire burning his face. Second degree burns to upper and lower lip, right face, nose. Periorbital (around eye) swelling and edema of the lips. Patient will require transfer to a burn center. Disposition transferred to Hospital C.</p> <p>Record review of the hospital C progress note dated 1/13/25 revealed R401 presents to the emergency department as a transfer after a facial burn sustained while smoking on home oxygen. Sustained ~1.5% partial thickness burns to right side of face. admitted to burn service. Integumentary: warm, dry ~1.5 % partial thickness burns to right side of face. Lips swollen with some partial thickness burns.</p> <p>On 1/15/25 at 2:55 PM Licensed Practical Nurse (LPN) D was interviewed and said she was called to R401's room on 1/10/25 by Sitter E. LPN D stated, R401 said he fell in the bathroom. His face appeared red. He was wearing his oxygen when I arrived, the oxygen tubing was intact.</p> <p>On 1/15/25 at 3:45 PM LPN F was interviewed and said that on 1/11/15 R401 requested to go to the hospital. R401 told me he fell the night before (1/10/25), I saw that his face was swollen.</p> <p>On 1/15/25 at 4:00 PM the facility's Chief Operating Officer (COO) I provided hospital C progress notes and acknowledged R401 was treated in the hospital for facial burns.</p> <p>On 1/15/25 at 4:50 PM Sitter E was interviewed by phone and said that she worked with R401 on 1/10/24 from 3PM to 11PM. Around 10:30 PM R401 went to the bathroom by himself and yelled. He was wearing his oxygen. He said he fell . Sitter E said she did not smell smoke, nor did she see any burns on R401's face. Sitter E said she took R401 out to smoke on 1/10/25 around 8:00 PM by herself. Sitter E interrupted the interview and did not respond to further attempts for an interview.</p> <p>On 1/16/25 at 2:15 PM and 3:33 PM Sitter E was called for an interview. Left messages with no return call.</p> <p>On 1/16/25 at 10:54 AM LPN G was interviewed and said she was the was the nurse supervisor on 1/10/25 and on 1/11/25. On 1/11/25 she put in a stat (immediate) order for an xray of R401's face due to his complaints of pain. LPN G said when she saw R401 on 1/11/25 R401 had swelling to his right eye and He had grease on his face like Vaseline. LPN G further said that R401 had a sitter for behavioral issues but could not specifically state the reason why R401 had a sitter.</p> <p>On 1/16/25 at 12:07 PM LPN H was interviewed and said that he observed emergency medical services pick up R401 on 1/11/25 to take him to the hospital. LPN H said R401 did not have any open wounds on his face when he was transported to the hospital but R401's face was swollen.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 1/16/25 at 2:50 PM Certified Nursing Assistant (CNA) J was interviewed and said that she worked with R401 on 1/11/25 day shift from 7AM to 3PM. CNA J said she saw R401 at approximately 1:30 PM on 1/11/25. CNA J stated, I thought R401 went to the hospital because his face it looked bad. He was drooling, he couldn't close his mouth. His face was pink including his lips. Everything was pink around his oxygen canula.</p> <p>On 1/16/25 at 3:49 PM the Director of Nursing (DON) was interviewed and said R401 was sent to the hospital following his fall per the resident request. The DON said R401 experienced combustion in August 2024, smoking while on oxygen and set his face on fire. When asked what was put in place to prevent further smoking incidents with R401 the DON said a 24-hour sitter was added. When asked were the sitters made aware for what to watch for with R401 the DON replied, The sitter is aware that there is some type of safety concerns, but I'm not sure of the specific reason why they are there is shared with them. The DON agreed the specific reason why the sitter is needed should be shared with the sitters to provide resident safety.</p> <p>On 1/16/25 at 3:55 PM the NHA was interviewed and said sitters should be told the specific reason why they are there to monitor residents so that it is clear why the resident needs supervision.</p> <p>Review of R401's care plan revealed Focus: I am a smoker, and I am aware that I need to follow the smoking policy. I have violated the smoking policy, and it resulted in me being injured. Date initiated 8/30/24. Goal: I will follow the smoking policy. Thru next review date. Date initiated 8/30/24. Target date 3/3/25. Interventions: I am aware that a lighter nor cigarettes can be keep on my person or in my room or possession. Date initiated 10/3/24. I am aware that I can only smoke at smoking times with supervision. Date initiated 10/10/24. I am aware that I will be offered a smoking patch or smoking gum if I violated the policy. Date initiated 10/3/24. I require a sitter at my bedside for safety date initiated 11/27/24. I understand if I violated the smoking policy that I will lose my smoking privileges for 7 days or I maybe involuntary discharge from the facility. Date initiated 10/3/24.</p> <p>Further review of R401's care plan revealed Focus: The resident has oxygen therapy related to a diagnosis of COPD as evidenced by low oxygen saturation and shortness of breath. Date initiated 8/21/24. Goal I will be complaint with oxygen therapy. My oxygen saturation will be between 95 and 100 percent. Date initiated 8/21/24 Target date 3/3/25. Intervention: I was educated about the importance of not using flammables around oxygen therapy. Date initiated 8/30/24.</p> <p>On 1/16/25 at 4:45 PM the facility's COO I was interviewed and R401's care plan was reviewed. The COO I said that the DON created the I require a sitter at my bedside for safety date initiated 11/27/24 on 1/15/25. The COO I agreed R401's care plan was not revised to have a sitter until 1/15/25.</p> <p>Review of R401's orders revealed:</p> <p>Cleanse face with normal saline, apply tiple antibiotic ointment and leave open to air created on 1/11/25 at 12:17 AM.</p> <p>STAT (immediate) x-ray of the optic and nasal bone to rule out a fracture 2 views per MD (medical doctor) created on 1/11/25 at 1:53 PM.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Cleanse face with normal saline, apply triple antibiotic ointment and leave open to air created on 1/11/25 at 2:07 PM.</p> <p>Transfer to hospital Created 1/11/25 at 3:07 PM.</p> <p>Transfer to Receiving Hospital created on 1/11/25 at 3:07 PM.</p> <p>Review of R401's most recent smoke assessment dated [DATE] revealed, safe to smoke with supervision.</p> <p>On 1/21/25 at 12:30 PM Medical Doctor (MD) K was interviewed and said R401 had been hospitalized for facial burns. When asked how he was informed of R401's hospitalization MD K replied I was told by a nurse from the facility that R401 was in the hospital with facial burns. MD K stated I assume R401 smoked in his bathroom just like he did last time he got a burn because residents don't wear oxygen outside when they smoke.</p> <p>On 1/21/24 at 2:00 PM R401 was interviewed at Hospital L. R401 was observed as an African American male with dark colored skin. R401's tip of nose was pink in color missing skin, top lip pink in color missing skin, bottom lip was scabbed. Both lips appeared swollen. R401's right cheek appeared pink in color missing skin. R401 knew he was at hospital L, his name and the date. When asked what happened on 1/10/25 R401 replied I lit a cigarette in my bathroom while wearing my oxygen and lit my face on fire. I told everyone that I fell and injured my face, but they knew what happened. I didn't fall. I didn't want the staff to get in trouble for what I did. I had my own cigarette and lighter from earlier in the day. The sitter didn't take back my cigarette and lighter from the earlier smoke break.</p> <p>On 1/22/25 at 9:45 AM Activities Director (AD) M was interviewed and said that she completes a resident assessment before a resident is allowed to smoke to make sure residents are safe. AD M said activities staff keep residents' cigarettes and lighters locked up when not in use and smoke breaks occur daily at 9:45 AM, 1:15 PM and 6:30 PM. Only staff handles the lighter, residents do not get to use the lighter. AD M said security monitors the evening smoke break at 6:30 pm. AD M stated, The only staff authorized and trained to take residents out to smoke are nurses, activities staff and security staff. When asked did you train Sitter E on how to monitor residents for smoking AD M replied No I did not train her (Sitter E).</p> <p>On 1/22/25 at 10:41 AM Activities assistant N was interviewed and said she worked and monitored the morning and afternoon smoke breaks on 1/10/25 and that R401 did not participate in either smoke break.</p> <p>On 1/22/25 at 12:01PM Security Staff (SS) O was interviewed and said he worked the evening shift on 1/10/25 and that R401 did not go out for the 6:30 PM scheduled smoke break. SS O stated I have seen sitters go out with R401 to supervise him smoke by themselves not during a scheduled smoke break. He (R401) was the only guy I know with a sitter who smokes. I have given cigarettes and a lighter to the sitter to go out with R401 to smoke. SS O said R401 was not allowed to go on leaves of absence and that he expected the sitters to monitor the resident during smoke breaks for safety.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Beaconshire Nursing Centre		STREET ADDRESS, CITY, STATE, ZIP CODE  21630 Hessel Detroit, MI 48219	
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 1/22/25 at 1:20 PM the NHA was interviewed and said nursing, activities staff and security are the only employees trained and authorized to take residents out to smoke. The NHA said the staff educator and activities director are the only staff allowed to train employees to supervise residents who smoke.</p> <p>On 1/22/25 at 1:35 PM the Staff Educator (SE) P said that sitters are not trained and/or authorized to take out residents to supervise smoking. When asked if Sitter E was trained to independently take a resident out to smoke SE P replied, Sitter E was not specifically trained to supervise smokers.</p> <p>On 1/22/25 at 1:38 PM the NHA said the only staff authorized and trained to supervise residents who smoke are nurses, activities staff and security personnel. No one else.</p> <p>A review of the facility policy titled Smoking Policy, revised 8/30/24 revealed in part: The policy of this facility is to provide a safe smoking environment for residents who can smoke and are deemed a safe smoker based on a comprehensive smoking safety assessment. All cigarettes and lighters will be labelled with resident's name and kept in a box at the security station and the staff member assigned to supervise smoking will be responsible for obtaining the box and distributing cigarettes and lighters to residents as well as collecting them and (sic) returning the box to the security office. If you do not make it out to smoke break on time you will have to wait for the next smoke break! No exception!</p> <p>The Immediate Jeopardy that began on 1/10/25 was removed on 1/22/25 when the facility took the following actions to remove the immediacy:</p> <ul style="list-style-type: none"> <li>-Beginning 1/22/25- The Director of Nursing/designee began an in-service with licensed nursing staff on independent smoker and dependent smokers, including resident choice of time smoking.</li> <li>-Beginning 1/22/25- All residents who smoke will be in-serviced by the Director of Nursing/designee on the smoking policy during a special resident council meeting to include the nonadherence to the policy that may result in revoking privileges and/or initiating a discharge plan care (sic).</li> <li>-Beginning 1/22/25 - Smoking signs were implemented asking families and visitors to not give residents smoking materials for the safety of our residents and turn in all smoking materials to be used only during scheduled smoking times.</li> <li>-Beginning 1/22/25 Staff was in-service on the updated smoking policy; to report any residents with smoking material immediately, staff includes security and sitters, and the updated policy includes reporting immediately to the charge nurse and management if any resident have any smoking materials and residents will be searched immediately.</li> <li>-Beginning 1/22/25 unscheduled smoking times will not be permit (sic) without approval from administration. Residents that smoke will be offered a nicotine patch or offered to be taking (sic) out to smoke with a nurse or Cena.</li> </ul>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47964</p> <p>This citation pertains to intake MI00149479.</p> <p>Based on observation, interview, and record review the facility failed to maintain complete and accurate medical records for one resident (R401) out of three residents reviewed for accidents, resulting in the absence of accurate documentation of R401's facial burns.</p> <p>Findings Include:</p> <p>On 1/13/2025 at 11:34 AM the State Agency received a complaint that on 11/10/2025 R401 lit a cigarette while on oxygen and lit his face on fire.</p> <p>On 1/15/2025 at 10:50 AM R401's guardian A was interviewed and said a staff member from the facility called to notify him on 1/11/25 or 1/12/25 that R401 lit his face on fire smoking again in his bathroom and was at hospital C for the treatment of facial burns.</p> <p>On 1/21/24 at 2:00 PM R401 was interviewed at Hospital L. R401 was observed as an African American male with dark colored skin. R401's tip of nose was pink in color missing skin, top lip pink in color missing skin, bottom lip was scabbed. Both lips appeared swollen. R401's right cheek appeared pink in color missing skin. R401 knew he was at Hospital L, his name and the date. When asked what happened on 1/10/25, R401 replied I lit a cigarette in my bathroom while wearing my oxygen and lit my face on fire. I told everyone that I fell and injured my face, but they knew what happened. I didn't fall. I didn't want the staff to get in trouble for what I did. I had my own cigarette and lighter from earlier in the day. The sitter didn't take back my cigarette and lighter from the earlier smoke break. The facility called EMS the next day after I kept asking them to send me to the hospital because my face hurt from the burns, and I couldn't breathe good.</p> <p>Record review of R401's Electronic Health Record (EHR) revealed admitted to facility on 3/6/2024 with most recent readmission on 1/19/2025 with diagnoses which included subdural hemorrhage, chronic obstructive pulmonary disease (COPD), schizophrenia, adjustment disorder with mixed anxiety and depressed mood.</p> <p>Review of the Minimum Data Set (MDS) dated [DATE] for R401 revealed a Brief Interview for Mental Status (BIMS) of 10/15 which indicated moderate cognitive impairment and partial/moderate assistance for transfers.</p> <p>Review of the facility progress note dated 1/10/2025 at 10:30 PM revealed, Writer observed injury when rounding on resident. Resident stated he fell in the bathroom. Writer assessed resident vital signs as follow 148/74 pulse 98, respirations 18, oxygen saturation 96% via nasal cannula. Temperature 97.8. Wound care provided resident tolerated well. R401 admitted during interview he lit his face on fire on 1/10/25, and staff were aware of the incident.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Skin Observation Tool dated 1/10/2025 at 10:57 PM revealed, Skin Tear to nose, upper lip and forehead, site Face type skin tear. R401 admitted during interview he lit his face on fire on 1/10/25, and staff were aware of the incident.</p> <p>Review of the facility progress note dated 1/11/2025 at 13:33 (1:33 PM) revealed, New order for stat x-ray of the optic and nasal bone to rule out a fracture 2 views per doctor. R401 admitted during interview he lit his face on fire on 1/10/25, and staff were aware of the incident.</p> <p>Review of the facility progress note dated 1/11/25 at 15:08 (3:08 PM) revealed, Resident requested to transfer to the hospital physician and guardian notified. R401 admitted during interview he lit his face on fire on 1/10/25, and staff were aware of the incident.</p> <p>Review of R401's EHR revealed neurological checks were documented on 1/10/25 and 1/11/25. R401 admitted during interview he lit his face on fire on 1/10/25, and staff were aware of the incident.</p> <p>Review of the facility progress note dated 1/11/25 at 20:42 revealed, Resident is transferred to hospital B at 7:15PM as per instructions provided by outgoing nurse and doctor, writer received recent Xray result, xray report stated the orbit demonstrate no acute fracture. No joint dislocation. Unremarkable soft tissues, medical doctor and Guardian A are notified. R401 admitted during interview he lit his face on fire on 1/10/25, and staff were aware of the incident.</p> <p>Review of the Prehospital Care Report by Emergency Medical Services (EMS) dated 1/11/25 revealed, EMS responded to priority 2 to facility for difficulty breathing. EMS arrived on location with no incident. EMS entered the building and located the patient room. EMS received report from the nursing. EMS entered the room and made patient contact. Patient was found standing using an oxygen concentrator as a brace. Patient was hooked up on oxygen flowing at 8LPM via nasal cannula. Patient presented baseline with no current complaints of pain. Patient had burn marks on his face from the prior night, nursing home staff informed EMS that the burns were from a cigarette from the prior night. EMS began transport to [NAME] Grace Hospital emergency room (ER) priority 1 for facial burns. EMS swapped the patients nasal cannula for a non-rebreather mask due to patient complaint of difficulty breathing. EMS arrived at [NAME] Grace ER with no incident. Patient arrived at Destination Date/Time 2025-01-11 20:28:24.</p> <p>Record review of the Hospital B emergency Treatment note dated 1/11/2025 at 21:10 revealed, (R401) with a history of COPD on home oxygen presents emergency department facial burn. Patient states last night (1/10/25) he was on his nasal canula oxygen and attempted to smoke a cigarette causing the nasal cannula to light on fire burning his face.</p> <p>Second degree burns to upper and lower lip, right face, nose. Periorbital (around eye) swelling and edema of the lips. Patient will require transfer to a burn center. Disposition transferred to (Hospital C.)</p> <p>Record review of the Hospital C progress note dated 1/13/25 revealed, (R401) presents to the emergency department as a transfer after a facial burn sustained while smoking on home oxygen. Sustained ~1.5% partial thickness burns to right side of face. admitted to burn service. Integumentary: warm, dry ~1.5 % partial thickness burns to right side of face. Lips swollen with some partial thickness burns.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/15/25 at 2:55 PM Licensed Practical Nurse (LPN) D was interviewed and said she was called to R401's room on 1/10/25 by Sitter E. LPN D stated, R401 said he fell in the bathroom. His face appeared red. He was wearing his oxygen when I arrived, the oxygen tubing was intact. When asked did R401 have facial burns LPN D replied, The only thing I saw was redness to his face. R401 admitted during interview he lit his face on fire on 1/10/25, and staff were aware of the incident.</p> <p>On 1/15/25 at 3:45 PM LPN F was interviewed and said that on 1/11/15 R401 requested to go to the hospital. When asked did R401 have facial burns LPN F replied, (R401) told me he fell the night before (1/10/25) I saw an abrasion on his face and his face was swollen. R401 admitted during interview he lit his face on fire on 1/10/25, and staff were aware of the incident.</p> <p>On 1/15/25 at 4:00 PM the facility's Chief Operating Officer (COO) I provided Hospital C progress notes and acknowledged R401 was hospitalized for facial burns.</p> <p>On 1/15/25 at 4:50 PM Sitter E was interviewed by phone and said that she worked with R401 on 1/10/24 from 3PM to 11PM. Around 10:30 PM R401 went to the bathroom by himself and yelled. He was wearing his oxygen. He said he fell . I called for nurse LPN D. Sitter E said she did not smell smoke, nor did she see any burns on R401's face. Sitter E said she took R401 out to smoke on 1/10/25 around 8:00 PM by herself. Sitter E abruptly ended the interview and did not respond to further attempts for an interview. R401 admitted during interview he lit his face on fire on 1/10/25, and staff were aware of the incident.</p> <p>On 1/16/25 at 2:15 PM and 3:33 PM Sitter E was called for an interview. Left messages with no return call.</p> <p>On 1/16/25 at 10:00 AM the Nursing Home Administrator (NHA) was interviewed and said she was told R401 fell and injured his face.</p> <p>On 1/16/25 at 10:54 AM LPN G was interviewed and said she was the nurse supervisor on 1/10/25 and on 1/11/25. On 1/11/25 she put in a stat (immediate) order for an Xray of R401's face due to his complaints of pain. LPN G said when she saw R401 on 1/11/25 R401 had swelling to his right eye and He had grease on his face like Vaseline. LPN G further said that R401 had a sitter for behavioral issues but could not specifically state the reason why R401 had a sitter. R401 admitted during interview he lit his face on fire on 1/10/25, and staff were aware of the incident.</p> <p>On 1/16/25 at 12:07 PM LPN H was interviewed and said that he observed EMS pick up R401 on 1/11/25 to take him to the hospital. LPN H said he assisted EMS for the hospital transfer. LPN H stated, R401 did not have any open wounds on his face when he was transported to the hospital but R401's face was swollen. R401 admitted during interview he lit his face on fire on 1/10/25, and staff were aware of the incident.</p> <p>On 1/16/25 at 2:50 PM Certified Nursing Assistant (CNA) J was interviewed and said that she worked with R401 on 1/11/25 day shift from 7AM to 3PM. CNA J said she saw R401 at approximately 1:30 PM on 1/11/25. CNA J stated, I thought R401 went to the hospital because his face it looked bad. He was drooling, he couldn't close his mouth. His face was pink including his lips. Everything was pink around his oxygen canula. R401 admitted during interview he lit his face on fire on 1/10/25, and staff were aware of the incident.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/16/25 at 3:49 PM the Director of Nursing (DON) was interviewed and said R401 was sent to the hospital following his fall per the resident request. The DON said R401 experienced combustion in August 2024, smoking while on oxygen and set his face on fire. The DON agreed R401 was admitted to the hospital with facial burns. R401 admitted during interview he lit his face on fire on 1/10/25, and staff were aware of the incident.</p> <p>Review of R401's EHR for January 2025 did not reveal any documentation related to facial burns. In addition, an acute care transfer sheet (provided by the facility) was not completed or available for review as requested, for the hospital transfer on 1/11/25. The acute care transfer sheet would have documented the reason for R401's transfer to an acute care facility. R401 admitted during interview he lit his face on fire on 1/10/25, and staff were aware of the incident.</p> <p>On 1/21/25 at 12:30 PM Medical Doctor (MD) K was interviewed and said R401 had been hospitalized for facial burns. When asked how he was informed of R401's</p> <p>hospitalization MD K replied, I was told by a nurse from the facility that R401 was in the hospital with facial burns. R401 admitted during interview he lit his face on fire on 1/10/25, and staff were aware of the incident.</p> <p>Review of the facility policy titled, Documentation in Medical Record date reviewed/ revised 1/16/25 revealed in part: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. 1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy . 4. Principles of documentation include, but are not limited to: a. Documentation shall be factual, objective, and resident centered. i. False information shall not be documented. B. Documentation shall be accurate, relevant, and complete, containing sufficient details about resident's care/or responses to care.</p>		