STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265238	A. Building B. Wing	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milan Health Care Center	52435 Infirmary Road Milan, MO 63556

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 44665 Based on interview and record review, the facility failed to provide protective oversight to ensure residents did not have materials to start a fire after staff identified a fire had been started in Resident #1 and Resident #2's room. On 1/12/25 at approximately 12:45 A.M., staff noted an odor coming from Resident #1 and Resident #2's room. Resident #1 said there was a small fire in the bathroom trash can that he/she extinguished with water. Staff noted a small amount of melted plastic in the bathroom trash can. Staff searched the room and found cigarettes in Resident #2's drawer, ashes in Resident #2's bed, and a cigarette butt on Resident #1's side of the room. Staff did not locate a lighter or any other lighting materials. On 1/12/25 at 1:07 A.M., the fire alarm sounded and at 1:09 A.M. staff observed Resident #1 walk up the hall. Staff noted a red glow and flames coming from the resident's room. Staff responded and found a box on fire on Resident #1's side of the room by the door. Staff extinguished the fire while other staff evacuated residents to the common area and called a Code Red (fire emergency that requires immediate attention). Resident #2 was transferred to the emergency room for evaluation as a result. A sample of ten residents was selected for review. The facility census was 92. The administrator was notified of the Immediate Jeopardy (IJ) on 1/16/25 at 3:04 P.M. which began on 1/12/25. The IJ was removed on 1/20/25 as confirmed by surveyor onsite verification. Review of the facility policy titled Smoking Contraband, reviewed 5/18/24, showed the following: -The purpose of the policy was to define what the facility classifies as smoking contraband and to provide safety and protective oversight to the residents and employees by monitoring the smoking contraband in the facility. It was the goal of the facility to provide a safe environment for all; -The facility defined contraband as cigarettes, electronic cigarettes, cigars, vaporizing electronic cigarettes, tobacco, lighters, matches, any other smoking materials (including illegal substances), and any other type of smoking device utilized to smoke; -Residents will not be allowed to carry or keep any smoking contraband on the unit or in their rooms; -Residents who have been assessed to be safe to smoke unsupervised and have purchased their own smoking contraband, will be allowed to sign out their own personal smoking contraband from the staff to utilize when they wish to smoke; (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Unused personal smoking contraband must be turned back into the facility staff and signed back in when the resident returns to the unit; -Facility staff must initial and sign all smoking contraband out and back in to keep an accurate record and account of all smoking contraband on the unit; -In the event that smoking contraband was unable to be located, or was not properly turned in, the charge nurse will be notified. Assessment of independent smoking will be reassessed should smoking contraband not be turned in and was found on their person or in their possession on the unit or in their rooms. The staff will ensure the Resident Care Coordinator (RCC), Director of Nursing (DON), administrator and legal guardian (if applicable) was notified; -Further direction may be given by the facility administrator and/or the legal guardian for resident/room searches to locate the smoking contraband. 1. Review of Resident #1's smoking safety evaluation, dated 12/11/24, showed the resident used tobacco and was an unsupervised smoker. Review of the resident's annual Minimum Data Set (MDS, a federally mandated assessment instrument required to be completed by facility staff), dated 12/17/24 showed the following: -Diagnoses included depression and schizophrenia (a chronic mental illness characterized by significant disruptions in thought processes, perceptions, emotions, and behaviors); -Mild cognitive impairment; -Hallucinations (perpetual experiences in the absence of real external sensory stimuli) present; -Independent with mobility. Review of the resident's Care Plan, revised 12/29/24, showed the following: -The resident had mental illness with history of frequent psychiatric hospital admissions. Provide 1:1 interventions as needed; -The resident tended to wander and think rules do not apply to him/her. Mood was labile, elevated/expansive. The resident communicated inappropriately, had poor concentration, judgment and insight. Recommended for the resident to be in a locked facility. Staff will observe for and report behaviors and redirect the resident when negative behaviors are observed; -The resident had behavioral challenges that required protective oversight in a secure setting. The resident had diagnoses of paranoid schizophrenia (subtype of schizophrenia that's characterized by paranoia, hallucinations, and delusions), polysubstance abuse, impulse control disorder (a group of mental health conditions characterized by difficulty controlling impulsive behaviors and thoughts), psychotic disorder (a mental health condition characterized by a loss of touch with reality), borderline intellectual functioning, developmental delay and dependent personality disorder; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The resident is a smoker and required supervision while smoking. Instruct the resident on the facility smoking policy, locations, times and safety concerns. Notify the charge nurse immediately if it was suspected the resident has violated the facility smoking policy. Review of a list of residents who smoke, provided by the facility on 1/14/25, showed Resident #1 was an unsupervised smoker. 2. Review of Resident #2's undated face sheet showed the following: -Diagnoses included paranoid schizophrenia and chronic obstructive pulmonary disease (COPD, a progressive lung disease that makes it difficult to breathe. Review of the resident's Care Plan, revised 4/3/24, showed the following: -The resident is a full-time smoker and was aware of the smoke break times and the designated smoking area; -Independent with activities of daily living; -The resident was at risk for impaired respiratory status due to smoking. The resident smoked cigar type cigarettes with unsupervised smoking groups. Sometimes the resident would save cigarette butts if there were a few puffs left and put them in his/her pocket and take it to the next cigarette break, despite staff education; -The resident would attempt to hide lighters to smoke at nonsmoke break times; -Conduct a smoking safety evaluation upon admission and as needed; -Instruct the resident on the facility policy on smoking, locations, times and safety concerns; -The resident can smoke unsupervised; -The resident's smoking supplies were stored in the storage room on the unsupervised hall entrance; -Observe clothing and skin for signs of cigarette burns. Review of the resident's smoking safety evaluation, dated 6/1/24, showed the resident utilized tobacco products and was a supervised smoker. Review of the resident's Care Plan showed no update following the resident's smoking safety evaluation, dated 6/1/24, which identified the resident was a supervised smoker. Review of the resident's nurse's notes showed the following: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On 6/27/24 at 10:06 A.M., staff observed the resident in the courtyard with a lit cigarette. The resident was unable to truthfully tell staff how he/she got possession of the cigarette or the lighter. Staff reviewed the smoking contraband policy with the resident and discussed concerns of unsupervised smoking. Resident aware of changes to smoking limitations if further actions occurred. Resident verbalized understanding; -On 11/3/24 5:33 P.M., the nurse aide came to the nurse's station and asked the nurse to go down and smell the resident's room because it smelled of cigarettes. The nurse went with the aide to the resident's room and agreed the room smelled like a cigarette had been lit in the room. The nurse and aide lifted the resident's mattress and found a lighter that fell on to the floor between the bed and the nightstand. Staff confiscated the lighter. The resident returned to his/her room after seeing staff come out of the room. The resident was instantly upset and yelled at multiple staff members. The resident tried to say the lighter belonged to his/her roommate. The resident continued to be upset, yell and pointed a finger in the nurse's face. The resident's guardian was notified. The guardian said if the resident could not follow the rules or be respectful, he/she would not be allowed to smoke. The guardian instructed the resident there would be no smoking that night and the guardian would follow up with facility office staff the following day with further instructions. Review of the resident's smoking safety evaluation, dated 12/1/24, showed the following: -Supervised smoker; -Rummaged through ashtrays. Review of a list of residents who smoke, provided by the facility on 1/14/25, showed Resident #2 was a supervised smoker. Review of the resident's Care Plan showed no update to reflect the resident was a supervised smoker. 3. Review of the facility's timeline of events showed the following: -On 1/12/25 at 12:45 A.M., staff noted an odor in Resident #1 and Resident #2's shared room and a trash can with melted plastic and a melted/charred plastic bag in the sink; -Certified Nurse Aide (CNA) A reported to charge nurses Licensed Practical Nurse (LPN) B and LPN C, and all three staff investigated; -During an interview with staff, Resident #1 said he/she did not start the fire or have a lighter. Resident #1 said he/she was cupping water with his/her hands to put out the fire and said the fire was approximately the size of his/her cupped hands; -Staff asked Resident #1 to empty his/her pockets and he/she did, producing a burnt end cigarette butt with charring to the pocket of his/her jacket; -During the room search, staff found approximately six cigarettes from Resident #2's (Resident #1's roommate) possession. Resident #2 denied possession of a lighter; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On 1/12/25 at 1:07 A.M., the fire alarm company submitted first warning trigger; -On 1/12/25 at 1:09 A.M., CNA A observed flames and smoke and called a Code Red as simultaneously the fire alarm panel alarmed; -LPN C called 911; -As staff responded, Resident #1 was observed walking in the hallway, in the opposite direction of the fire towards the common area; -Staff evacuated Resident #2 from the room as well as residents in the adjoining room (connected by a bathroom); -LPN B and LPN C extinguished the fire with a fire extinguisher through the resident's doorway; -Staff checked rooms and closed doors as the location was evacuated and secured and brought other residents to the common area; -On 1/12/25 at 1:12 A.M., staff notified the DON; -On 1/12/25 at 1:13 A.M., staff notified the ADON (Assistant Director of Nurses); -On 1/12/25 at 1:30 A.M., the fire department arrived on scene with police and emergency medical services (EMS); -Staff completed room searches and utilized a fan to ventilate and removed a burned box from the scene; -On 1/12/25 at 1:31 A.M., the administrator was made aware; -Resident #2 was transferred to the emergency room and treated for COPD exacerbation. During an interview on 1/14/25 at 9:00 P.M., CNA A said he/she walked down the hall and smelled something burning which he/she reported to LPN B and LPN C. The staff searched the room and found some new cigarettes and old butts in Resident #2's dresser. One of the resident's coats was found with a burn mark and a cigarette butt in the pocket. No lighters were found. Staff left the room when the search was completed. About 20 minutes later CNA A noticed a red glow coming from the room and called a Code Red. At this time Resident #1 walked up the hallway. Another staff member got Resident #2 out of the room as other staff extinguished the fire. The fire was located in a box that was on Resident #1's side of the room by the door. The box contained a couple of coats and papers and odd and ends. Resident #1 was seated on a couch in the common area, rocking back and forth. Resident #1 appeared anxious and CNA A could tell something was off. Resident #2 had a habit of hiding lighters. It was unknown how Resident #2 acquired them. Staff are to keep all smoking materials including lighters. Staff hang their coats on the 200 hall or in the shower room as there are not enough lockers for all staff to have one. CNA A has told night shift in the past to be sure and keep their lighters on their person. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/14/25 at 4:50 P.M., LPN C said CNA A reported to him/her and LPN B a smell like something was burning. LPN C and LPN B went to Resident #1 and Resident #2's room. Resident #1 stood beside the bed, Resident #2 lay in his/her bed. Resident #1 said there was a little fire in the bathroom, but he/she had put it out with water. LPN C removed the melted trash can liner where the fire had been located. It was not hot. LPN B and LPN C searched the room and bathroom and found a cigarette in Resident #1's night stand drawer and ashes in Resident #2's bed and a burn mark on the inside of Resident #2's jacket pocket. LPN C and LPN B left the room and went to the desk and notified supervisors. Resident #2 went back to sleep. Approximately 10 to 15 minutes later, CNA A yelled out, Code Red!. LPN C saw flames coming from Resident #1 and #2's room. LPN C grabbed a fire extinguisher. Resident #1 walked up the hallway, away from the room and towards the common area. Resident #1 looked nervous and sat on the couch. LPN C extinguished the fire with the extinguisher. The fire department arrived and removed the box that was burned from the room. The fire department cleared residents to return to their rooms. Staff searched the room again. LPN B interviewed Resident #1 and Resident #2 about the fire. LPN C assessed the residents. Resident #2's breathing became worse and was sent to the emergency room for evaluation around 10:00 A.M. Resident #1 and Resident #2 has been known to dig through the ashtrays for cigarette butts in the past. Review of the written statement obtained by the surveyor from LPN C, dated 1/15/25, showed the following: -On 1/12/25 at 12:45 A.M., CNA A came to the nurse's station and reported there was a smell of something burning. LPN B and LPN C went down the hall and followed the smell to Resident #1 and Resident #2's room; -LPN B and LPN C entered the room and there was a strong odor of smoke; -Resident #1 sat on his/her bed and said there was a small fire in the bathroom trash can that he/she put water on; -LPN B and LPN C observed a melted trash bag in the trash can and ashes in the sink in the bathroom; -Aides searched the room for contraband as LPN B and LPN C went back to the nurse's station to notify supervisors; -Aides found contraband on both Resident #1's and Resident #2's side of the room and brought it to the nurse's station; -At 1:00 A.M., CNA A yelled Code Red and Resident #1 and 2's room number; -Staff observed flames coming from the room and Resident #1 walking away from the room towards the common area; -LPN C grabbed the fire extinguisher as CNA A woke up Resident #2 and evacuated him/her from the room; -All aides began to evacuate all residents from their rooms to the common area; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-At 1:09 A.M., staff called 911; -Immediately after the fire department cleared the smoke from the hallway, fire department staff searched rooms. The fire department cleared all residents to return to their rooms, expect the four residents whose rooms were affected due to smoke and fire damage; -Staff assessed Resident #1 and Resident #2. Resident #2's assessment showed wheezes in his/her lungs and an oxygen saturation level (the percentage of oxygen molecules carried by red blood cells. Normal is between 95% and 100%) of 84%. Staff applied supplemental oxygen at 3 liters per nasal cannula and Resident #2's oxygen saturation increased to 91%; -LPN B interviewed Resident #1 and Resident #2 separately about what happened. During an interview on 1/16/25 at 12:55 P.M., CNA E said after the first fire he/she helped with the room search to try and determine what started the fire. Staff searched everything, including under Resident #1's and #2's mattresses. Staff also searched the bathroom and the adjoining room. No lighter was found. As CNA D and CNA E started the 15 minute checks for the four residents in the room and adjoining room where the first fire started, the big fire was observed. LPN C pulled the fire alarm and got the fire extinguisher and CNA A and CNA D got Resident #2 out of the room. Resident #1 was already in the common area. There was approximately 20 minutes between the fires. During an interview on 1/14/25 at 8:41 P.M., CNA D said he/she was told there had been a fire in a trash can on the 300 hall. When CNA D arrived to the room there were two other staff already searching the room. Staff found six or seven cigarettes in Resident #2's bedside table. CNA D observed ashes in Resident #2's bed around where the resident had laid, which he/she reported to LPN B and LPN C. No lighter was found. About 10 minutes later the fire alarm went off. CNA D ran back to the 300 hall which was full of smoke. Staff already had about half of the residents evacuated from the hall. After the first fire, Resident #1 was seated in the common area. At the time of the second fire, Resident #1 was no longer sitting in the common area. During an interview on 11/15/24 at 3:30 P.M. LPN B said he/she interviewed Resident #1 and Resident #2 after both fires. Neither resident admitted to having a lighter or starting the fire. After the first fire, the room was searched, including looking under their mattresses. No lighter was found. During an interview on 1/14/25 at 12:50 P.M., Resident #2 said he/she guessed Resident #1 started a fire in their room with a lighter, but he/she didn't see it because he/she was sleeping. The resident went to the hospital after the fire as he/she was not feeling well and returned to the facility from the hospital on 1/13/24. Resident #2 denied having a lighter or cigarettes or bringing cigarette butts back from smoke times. Resident #2 said he/she suspected Resident #1 brought cigarette butts back into the room, but could not prove this. During an interview on 1/16/25 at 11:41 A.M., the Assistant Director of Nursing (ADON) said the following: -After the first fire incident occurred, staff were to intensively monitor Resident #1 and keep him/her in staff's line of sight; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Intensive monitoring was defined as staff checking on residents at a frequency of less than an hour between each check and keeping the resident in line of sight; -Resident #1 was not placed on a 1:1 staff-to-resident monitoring because that was considered a within arms reach check and she and the Administrator did not feel the resident needed to be within arms length of staff, just that the resident was in the line of sight of staff; -She expected if staff saw Resident #1 enter his/her room during line of sight monitoring that staff follow him/her into his/her room; -No particular staff was assigned to monitor Resident #1, staff just made a team effort to monitor him/her. During interviews on 1/14/25 at 11:50 A.M. and 1/16/25 at 10:23 A.M., the Administrator said both Resident #1 and Resident #2 had a history of sneaking cigarette butts back into the facility after smoke times. Resident #2 was already a supervised smoker. Prior to the fires, Resident #1 was an unsupervised smoker. Staff were expected to extinguish supervised residents' cigarettes when finished. Staff were expected to empty the ashtrays after each smoke break and were expected to monitor the box of cigarettes and lighters at all times and not to leave them unattended around residents. Intensive monitoring, 15-minute checks, and staff having a resident in their line of sight were considered the same thing. After the fire incidents occurred, Resident #1 was not placed on 1:1 staff-to-resident monitoring with an assigned staff member. NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation(s). MO247905 MO247912