STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365250	A. Building B. Wing	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buckeye Care and Rehabilitation	1900 East Main Street Lancaster, OH 43130

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 Note: The nursing home is disputing this citation.	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** 42728 Based on observation, clinical record review, review of hospital progress notes, staff interview, resident interview, resident representative interview, and review of facility policy, the facility failed to maintain a safe outdoor smoking area for residents assessed to be independent with smoking, failed to ensure Resident #100 was accurately assessed for the ability to safely smoke without supervision, failed to ensure Resident #100 was appropriately assessed for the ability to extinguish herself in the event of a fire (she had hemiplegia and hemiparalysis of the left arm and leg and required assistance from two staff members for transfers), failed to ensure the resident had reasonable access to a fire blankets and/or fire extinguisher, and failed to ensure the resident had the means to obtain assistance in the event of a fire. This resulted in Immediate Jeopardy and serious physical harm on 05/12/24 when Resident #100, who was smoking in the facility designated smoking area caught on fire from an ash of her cigarette sustaining severe third degree burns to her upper body/face requiring hospitalization and surgical intervention. A visitor observed the resident to be on fire and utilized the sleeve of her shirt to extinguish the fire when the visitor was unable to locate a fire blanket in the designated smoking area. The resident was subsequently transferred to the hospital where she received treatment for the third degree burns to her upper body which required skin graft surgery. This affected one resident (#100) of three residents reviewed for safe smoking. The facility identified six additional residents (#2, #25, #26, #34, #47, and #78) who were assessed to be able to smoke independently. The facility census was 90. On 06/04/24 at 10:48 A.M., the Administrator and the Director of Nursing (DON) were notified Immediate Jeopardy began on 05/12/24 when the facility failed to maintain a safe smoking area for Resident #100 when the resident caught on fire while smoking. A visitor who responded after seeing the resident on fire had to utilize the sleeve of her sweatshirt to extinguish the resident because there was no fire blanket readily accessible in the designated smoking area. The Immediate Jeopardy was removed on 06/04/24 when the facility implemented the following corrective actions: On 05/12/24 Licensed Practical Nurse (LPN) #242 responded to Resident #100 after being notified the resident had caught fire. LPN #242 assessed Resident #100 for pain which the resident initially denied and refused a transfer to the emergency room . Later Resident #100 agreed to the hospital transfer, the transfer was facilitated, and the resident's representative was notified of the incident. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 05/12/24 after the incident occurred, the Administrator called Resident #100's representative and discussed the incident. On 05/12/24 the Administrator visited Resident #100 in the hospital. The Administrator stated the resident voiced concerns about losing her smoking privileges and also stated the wind blew amber out of her cigarette and caught her clothes on fire. The resident stated she had been wearing loose fitting clothing at the time of the incident and she thought she had swatted the amber off her but later realized she had not done so. On 05/12/24 Licensed Practical Nurse (LPN) #242 reviewed the current smoking residents in the facility with no injuries noted. All smoking evaluations were reviewed for accuracy and the plans of care was updated if needed for the residents reviewed. LPN #242 also instructed the residents on the location of the fire safety equipment, fire blanket, and ensured they understood how to use it. On 05/12/24 the Director of Nursing (DON) reviewed skin evaluations on all current residents and there were no signs of any injuries of unknown origin or injuries consistent with a smoking injury. On 05/12/24 LPN #242 observed independent smokers' clothing and no signs of damaged clothing consistent with a smoking incident were noted. On 05/12/24 LPN #242 re-educated current smoking residents on the importance of informing staff of any potential fire hazards immediately to prevent similar incidents from occurring. On 05/12/24 LPN #242 re-educated the current staff on the updated facility smoking policy. On 05/12/24 the Administrator met with the resident council to review the smoking policy, and to receive feedback from the residents related to the possibility of transitioning the facility to supervised smoking in the future. On 05/12/24 Regional Nurse Consultant (RNC) #800 incorporated fire safety equipment checks immediately, daily for four days, then monthly and as needed thereafter to ensure appropriate fire safety equipment was present and in functional order. On 05/12/24 Activities Director (AD)#294 started random audits on a minimum of five residents per week for four weeks then as needed to ensure residents were appropriately assessed and were smoking safely independently, avoiding loose and flammable clothing, and were taking appropriate precautions related to weather conditions. Any issues identified within the audits were to be forwarded to the Quality Assurance (QA) committee for immediate follow-up. On 05/12/24 Registered Nurse (RN) #319 provided staff, residents, and visitors with education regarding placement of the fire extinguisher and fire blanket. On 05/13/24 the Administrator obtained a quote for a gazebo to be placed in the smoking courtyard. On 05/15/24 Regional Nurse Consultant (RNC) #800 updated the smoking policy to include additional fire safety measures, such as having fire extinguisher in the smoking area, training residents on basic fire safety, and inspection and maintenance of fire safety equipment. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 05/15/24 AD#294 educated current smokers on the updated smoking policy, the current smokers were provided with a copy of the policy and signed an attestation of understanding. On 05/15/24 AD#294 placed signage on the facility doors informing and reminding residents and staff of the smoking rules and fire safety practices. On 05/15/24 the Administrator held a meeting with the Ombudsman and all independent smoking residents regarding the smoking policy, placement of the fire extinguisher, placement of the fire blanket, and the importance of verbalizing the need for assistance. On 05/30/24 a gazebo was placed within the courtyard by Maintenance Director (MD) #281. On 06/03/24 MD #281 placed a fire blanket on the gazebo. On 06/04/24 MD #281 moved the fire extinguisher to the designated smoking area. On 06/04/24 Occupational Therapist (OT) #318 assessed all independent smokers to ensure they were able to follow safety precautions related to fire safety and ensured residents were able to remove the fire blanket and understood how to use a fire extinguisher. The facility implemented a plan that on 06/04/24 by 11:59 P.M., the DON would educate all licensed nurses on how to complete a smoking assessment to ensure consistency. Licensed nurses would be responsible for completing smoking assessments moving forward. The education would include the new location of the smoking blanket in the designated smoking area. No agency staff were being utilized and no licensed nurses were on leave at the time of the training. On 06/04/24 AD #294 hung signs on the two handicapped accessible doors leading to the smoking area to ensure staff, residents, and visitors had knowledge of where the smoking blanket and fire extinguisher were located. On 06/04/24 the Administrator fastened a walkie talkie to the smoking gazebo for communication in the event of an emergency. The walkie talkie would be changed out daily to ensure it was charged. Beginning on 06/04/24 the DON or designee would complete weekly audits for four weeks and as needed to ensure the completed smoking observation/assessments were accurate and reflected the medical record. Beginning on 06/04/24 the DON or designee would complete weekly audits for four weeks and as needed to ensure the fire blanket, fire extinguisher, and walkie talkie were in place. Results of the audits would be reviewed during monthly Quality Assurance (QA) meetings to determine if the current action plan was effective or if additional interventions would need to be added. Any issues identified within the audit would be forwarded to the QA committee for immediate follow-up. Interviews on 06/04/24 from 3:35 P.M. to 3:50 P.M. with three licensed nurses (#242, #248, and #246) confirmed they had received education regarding the accurate completion of resident smoking assessments. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Although the Immediate Jeopardy was removed on 06/04/24, the deficiency remained at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective action and monitoring to ensure on-going compliance. Findings include: Review of the closed medical record for Resident #100 revealed the resident was admitted to the facility on [DATE] and had diagnoses including hemiplegia and hemiparalysis affecting the left non-dominant side, dysphagia, weakness, seizures, and need for assistance with personal care. The resident was transferred to the hospital on 05/12/24 and did not return to the facility. Review of the care plan for Resident #100 initiated 05/19/20 revealed the resident was a cigarette smoker and was safe to smoke independently per the smoking assessment. Interventions included staff were to complete smoking assessment prior to initiating smoking independently, quarterly, and as needed. Review of the care plan for Resident #100 initiated11/24/20 revealed the resident had an activities of daily living (ADL) self-care performance deficit and was noncompliant with safety interventions and mobility. Interventions included staff to provide assistance with transfers, bed mobility, personal hygiene, and dressing. Review of the care plan for Resident #10 initiated 11/17/21 revealed the resident had impaired visual function related to limited vision in the left eye. Interventions included reminding resident to wear glasses. Review of the care plan for Resident #100 initiated 07/21/23 revealed the resident had a diagnoses of seizure disorder and was at risk for complications. Interventions included the following: place the call light within reach and answer promptly and to maintain a safe environment, instruct resident on smoking risks and hazard, therapy as ordered to improve mobility, keeping smoking materials stored appropriately in the lock box, smoking at designated times per the facility policy. Review of the quarterly Minimum Data Set (MDS) assessment for Resident #100 dated 04/11/24, revealed the resident had intact cognition evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 15 (out of 15). The assessment indicated Resident #100 utilized a manual wheelchair for mobility and had functional limitation in range of motion present on one side of the upper and lower extremities. Record review revealed the Resident #100 required substantial/maximum assistance from staff for transfers. Review of the smoking observation/assessment for Resident #100 dated 05/03/24 completed by Activities Director #294 revealed the resident was a smoker or user of tobacco products. The resident was assessed to have no cognitive loss, visual deficits, or dexterity problems. The resident was assessed to be safe to smoke without supervision. Review of the physician's order for Resident #100 dated 05/12/24 revealed the resident was to be provided assistance from two staff members with use of a gait belt for transfers. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the nursing progress note for Resident #100 dated 05/12/24 at 12:31 P.M. and authored by Registered Nurse (RN) #319 revealed Resident #100 was outside smoking unsupervised in the smoking area. Someone yelled fire while standing by the windows to the courtyard. The nurse approached Resident #100 and a visitor was using the sleeve of her sweatshirt to put out the fire. Resident #100 was brought back inside and the Registered Nurse (RN) on shift was notified. The RN assessed Resident #100 and noted burns to both breasts, chest, neck, jaw, and face and the left side of the resident's face and her hair was burnt. The resident's shirt and bra had significant damage and staff removed them and placed a sheet over the resident. Staff called 911 due to the severity of the burns. Emergency medical service (EMS) personnel arrived at the facility and assessed the resident. Resident #100's representative was notified of the incident and the transfer, and the resident was taken to the hospital. Review of the Emergency Medical Services (EMS) report for Resident #100 dated 05/12/24 timed at 11:30 A. M. revealed upon (EMS) arrival to the facility the resident had sustained multiple first, second, and possibly even third degree burns to her chest, shoulders, neck, and the lower part of her face when her clothing caught fire while smoking the facility courtyard. The resident rated her pain as an eight on a scale of 1 to 10 with 10 being the worst pain and was administered intravenous Fentanyl (an opioid pain medication) at the facility with her pain level unchanged upon transfer to the emergency room . Resident #100 reported to EMS personnel that she was smoking when ashes from her cigarette caught her nylon sweater on fire. Review of the hospital progress note for Resident #100 dated 05/12/24 revealed the resident presented to this hospital with a chief complaint of significant burns. The resident stated she was on the porch smoking when her sweater burst into flames causing burns to her upper chest, neck, face, and shoulders. The resident had damage to her nasal hair, eyebrows, and hair on the scalp line. Resident #100 was borderline hypoxic upon arrival and was complaining of pain to her chest and face with burn to an estimated 15 to 18 percent (%) of her total body. Resident #100 was transferred to the emergency department of another hospital once stable for further treatment of the burns. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the hospital progress notes for Resident #100 dated 05/12/24 revealed the resident was transferred to this hospital for admission and treatment of burn injuries to the bottom half of face, anterior chest, and anterior bilateral upper extremities. Resident #100 reported at approximately 11:00 A.M. on 05/12/24 she was smoking a cigarette outside when a burning ash blew off in the wind and caught her nylon shirt on fire. Upon arrival to the hospital the resident was complaining of a pain level of 8 on a scale of 1 to 10. Resident #100 presented to the emergency department with burns to approximately 15 to 18 percent of her total body surface area with superficial and partial-thickness burns. Resident #100 had scattered blistering, some skin sloughing, and singed nasal hairs. The burn team evaluated the resident. Review of the [NAME]-[NAME] Total Burn Surface Area Chart revealed 0.5 percent of head burns were second degree burns, 0.5 percent of head burns were third degree burn, 0.5 percent of neck burns were second degree burns, 0.5 percent of neck burns were third degree burns, 10 percent of anterior trunk burns were second degree burns, two percent of anterior trunk burns were third degree burns, one percent of right upper arm burns were second degree burns, and one percent of left upper arm burns were second degree burns for a total burn area of 16 percent of the resident's body. Resident #100 underwent surgical excision and skin grafting of the face, anterior chest, chin, and neck on 05/15/24. Resident #100 was in the hospital for a total of 26 days undergoing post-operative treatment for her burns sustained while at the facility and was discharged to a new skilled nursing facility on 06/07/24. Resident #100 was scheduled for ongoing follow-up care of her burn injuries with the hospital burn clinic, and her first post-discharge visit was scheduled for 06/21/24. Review of a written statement completed by the Administrator dated 05/12/24 regarding an interview with Representative #500 revealed on 05/12/24 she was visiting in Resident #54's room when she saw smoke emanating from the facility courtyard and she realized Resident #100's clothing had caught on fire. Representative #500 yelled fire and ran to the courtyard. Representative #500 reported she extinguished the fire using the representative's own clothing. The statement did not indicate why Representative #500 used her clothing to extinguish the fire, nor did it include information regarding the location of the fire blanket and its proximity to the fire. On 06/03/24 at 10:10 A.M. observation of the facility designated area provided for residents who smoked revealed it was located on concrete pad in the middle of the facility courtyard. The concrete pad was surrounded by grass and had a concrete sidewalk leading around the side of the courtyard which looped back to the concrete pad. The designated smoking area included an ash tray and a red receptacle with a self-closing lid. There was no fire extinguisher or fire blanket observed in the designated smoking area. The fire extinguisher and fire blanket were in the courtyard hanging on a brick wall by the double glass doors. Maintenance Director #281 measured the fire extinguisher and fire blanket to be 85 feet away from the designated smoking area when taking the concrete sidewalk and 46 feet away when going through the grass. Interview with Ombudsman #901 on 06/03/24 at 10:30 A.M. revealed the ombudsman had concerns related to the extent of Resident #100's injuries (that occurred during the smoking incident on 05/12/24) and felt the incident needed to be investigated closely. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interview with Activities Director (AD) #294 on 06/03/24 at 12:15 P.M. revealed the facility smoking assessment was completed based on observation of residents' ability to get outside of the facility, accessing smoking materials in the locked boxes in the facility courtyard, safely lighting their own cigarettes, and safely smoking their cigarettes. The AD denied receiving any type of formal training on how to complete the assessments prior to the incident involving Resident #100. AD #294 confirmed record reviews were not utilized as part of the completion of the facility smoking assessment. AD #294 confirmed Resident #100 was documented on the assessment to not have any visual deficits or dexterity problems based on the observation at the time of the assessment. However, AD #294 confirmed Resident #100 had hemiplegia and hemiparalysis affecting her left side and likely would not have been able to wheel herself quickly to where the fire blanket was located in the event of a fire. Interview with State tested Nursing Assistant (STNA) #299 on 06/03/24 at 12:25 P.M. confirmed Resident #100 utilized a wheelchair for mobility, had hemiplegia and hemiparalysis of the left arm and hand, and required extensive assistance from two staff members for transfers and bed mobility. STNA #299 confirmed on 05/12/24 someone yelled fire and the STNA responded to find the fire (involving Resident #100) had already been put out. STNA #299 confirmed Resident #100 had burns all over her chest caused by her shirt catching on fire while smoking a cigarette and was sent to the hospital for evaluation. STNA #299 confirmed Resident #100 had no use of her left arm or leg and required assistance from two staff members for transfers. Interview with Registered Nurse (RN) #319 on 06/03/24 at 12:32 P.M. revealed on 05/12/24 she was notified by an STNA that Resident #100 was on fire. RN #319 confirmed she arrived to the resident's room to find the residents bra, shirt, and skin were burnt. RN #319 confirmed, prior to the incident, Resident #100 had been assessed to have visual deficits in her left eye and did not have use of her left arm, hand, or leg. Observation on 06/03/24 at 1:45 P.M. revealed Resident #26 had finished smoking independently in the facility courtyard and was propelling herself backwards in her wheelchair on the sidewalk towards the facility doors. During the onsite investigation, interview on 06/03/24 at 1:47 P.M. with Resident #26 revealed the resident utilized a wheelchair for mobility and could not safely propel herself through the grass toward the facility doors or location of the fire blanket. During the interview, Resident #26 stated it would take too long to propel in the manual wheelchair to the location of the fire blanket if she was on fire and stated she would burn up before she got there. Resident #26 confirmed there was no way to call for staff assistance from the designated smoking area in the event of a fire. In addition, an interview with Resident #78 on 06/03/24 at 2:05 P.M. revealed the resident utilized a wheelchair to propel on the sidewalk through the courtyard to the smoking area. Resident #78 confirmed the location of the fire blanket was not convenient to a resident who was on fire and there was no way to call for help from the smoking area in the event of a fire. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A telephone interview with Representative #500 on 06/03/24 at 2:23 P.M. revealed on 05/12/24 the representative was visiting with a resident, Resident #54 in Resident #54's room which had a window facing the facility courtyard when she observed smoke coming from the area. Representative #500 stated she knew the area was utilized for smoking and did not immediately believe it was cause for concern. Representative #500 stated a couple minutes later she observed what appeared to be a resident (identified to be Resident #100) on fire in the designated smoking area of the courtyard, and there was a significant amount of smoke coming from the resident. Representative #500 stated she ran out of the room and into the courtyard to where the resident was located and observed the resident's shirt had flames emanating from it. Representative #500 stated the resident was wide-eyed and appeared fearful. Representative #500 stated she looked around for a fire blanket and was not able to locate one. Representative #500 stated she pulled the sleeve to her sweatshirt over her hand and utilized it to put out the flames coming from the resident. Representative #500 stated facility staff arrived outside immediately after she put out the flames to assist the resident as the representative had instructed another resident to get help. Representative #500 stated on the way back inside the facility, she did observe the fire extinguisher and fire blanket next to the facility doors fastened to the brick wall. Representative #500 confirmed the fire extinguisher and fire blanket were not visible from the designated smoking area. Interview with Occupational Therapist (OT) #318 on 06/04/24 confirmed Resident #100 did not have use of her left hand or arm due to hemiplegia and hemiparalysis affecting the left side. A telephone interview with Representative #700 (for Resident #100) on 06/05/24 at 9:35 A.M. revealed Resident #100 suffered third degree burns as a result of catching on fire while smoking at the facility on 05/12/24 and required skin graft surgery on 05/14/24. Representative #700 revealed Resident #100 remained hospitalized as of this date (06/05/24) as a result of the injuries sustained on 05/12/24. Representative #700 confirmed Resident #100 utilized a manual wheelchair with a footrest for mobility and the resident had no use of her left arm and left leg. Further interview with Representative #700 revealed Resident #100 had required a blood transfusion on or about 06/03/24 and was exhibiting confusion which was abnormal for the resident following the incident. During the interview, Representative #700 revealed she was under the impression staff were supposed to be supervising Resident #100 when she smoked. Review of the facility smoking policy, revised 09/20/23 revealed the purpose of the policy was to ensure residents who smoke had a comfortable and safe environment in which to smoke. The policy indicated a fire blanket should be available in the smoking area to wrap around a resident whose clothes had caught alight. Review of the facility smoking policy, revised on 05/12/24 (following the incident with Resident #100), revealed the purpose of the policy was to ensure residents of the facility who smoked had a comfortable and safe environment in which to smoke. Smoking would be permitted in the courtyard's designated smoking area only, by the old brick grill. Fire safety measures, such as having a fire extinguisher in the smoking area and training residents on basic fire safety, were in place. There was to be a fire blanket available at the smoking area, which could be used to wrap around a resident whose clothes had caught fire. The policy contained an area for the resident and a facility representative to sign and date. This deficiency represents noncompliance investigated under Complaint Number OH00154361.