STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365745	A. Building B. Wing	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Swanton Valley Rehabilitation and Healthcare Cente	401 W Airport Hwy Swanton, OH 43558

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. Based on review of the medical record, observation, resident interview, staff interview, review of the facility policy, review of documentation on the National Institute of Health (NIH) website, and review of Public Safety Network guidance, the facility failed to ensure the residents environment remained as free from accident hazards as possible when one resident (#11) continued to use vape pens (an electronic device that uses a battery to heat up a special liquid into an aerosol that users inhale) in the presence of oxygen. This resulted in Immediate Jeopardy and the potential for serious physical harm and/or injuries, when Resident #11 was allowed to keep her vape pen in her room and was known to use it while wearing her oxygen, which increased the risk of potentially causing the oxygen gas to ignite from the heat of the vape pen. This affected one (Resident #11) of three residents reviewed for using vape pens. Additionally, facility staff failed to follow the facility's policy for residents to return their vape pens to staff when not in use, and not to vape unless in the designated smoking area. This affected two (#11 and #12) of three residents reviewed for use of vape pens. The facility census was 83. On 06/05/25 at 3:05 P.M., the Administrator, the Director of Nursing (DON) and Chief Nursing Officer #400 were notified Immediate Jeopardy began on 04/21/25 when Registered Nurse (RN) #201 observed and documented Resident #11 using her vape pen in her room while wearing her oxygen. The facility did not provide additional supervision and/or monitoring to ensure Resident #11 followed the facility policy not to use the vape pen inside the facility while wearing oxygen. On 06/05/25 at 8:14 A.M., Resident #11 was observed in her room with the vape pen stored in a container on her overbed table. At the time of the observation, Resident #11 stated she uses her vape pen in her room while wearing her oxygen. The Immediate Jeopardy was removed on 06/06/25, when the facility implemented the following corrective actions: • On 06/05/25 at 9:30 A.M., Resident #11 had all electronic smoking devices removed by the Director of Environmental Services (#305). • On 06/05/25 at 4:23 P.M., the staff nurse completed a head-to-toe assessment on Resident #11 with no negative effects due to the resident vaping in the room while using oxygen. (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	• On 06/05/25 at 4:45 P.M., Resident #11 was presented with an immediate discharge by the Administrator. The resident was accepted for admission to another skilled nursing facility in the same city. • By 06/06/25, the Administrator or designee will reassess residents who smoke and/or use electronic smoking devices for safety and/or needed supervision during smoking. • By 06/06/25, the Administrator or designee will audit all residents who smoke and/or use electronic smoking devices to ensure smoking materials are retained and distributed by the facility staff to the residents during the designated smoking times and/or when independent resident chooses to smoke. • By 06/06/25, the Administrator or designee will audit all residents who smoke and/or use electronic smoking devices to ensure they do not smoke or vape while using oxygen or in areas where oxygen is present. • By 06/06/25, the Administrator or designee will retrain all staff in all departments on the facility smoking policy and that smoking and/or vaping are prohibited while using oxygen or in areas where oxygen is present. • By 06/06/25, the Administrator or designee will retrain all residents who smoke and/or use electronic smoking devices on the smoking policy and have them all sign the policy. Residents will be retrained that smoking and/or vaping are prohibited while using oxygen or in areas where oxygen is present. • On 06/06/25 at 12:55 P.M., the facility initiated one-on-one monitoring of Resident #11 until she can be discharged . • Beginning 06/06/25 and continuing weekly for four weeks, the Administrator or designee will audit four residents who smoke and/or use electronic smoking devices to ensure smoking materials are retained and distributed by the facility staff to the residents during the designated smoking times and/or when independent resident chooses to smoke and to ensure they do not smoke or vape while using oxygen or in areas where oxygen is present. The audits will be submitted to the Quality Assurance (QA) committee for tracking, trending and recommendations. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Although the Immediate Jeopardy was removed on 06/06/25, the facility remains out of compliance at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: 1) Review of the medical record for Resident #11 revealed an admission date of 01/25/23. Diagnoses included heart disease, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, and tobacco use. Review of the quarterly Minimum Data Set (MDS) assessment, dated 05/12/25, revealed Resident #11 had intact cognition. Review of the care plan initiated 01/25/23, and revised on 02/05/24, revealed Resident #11 was a smoker and was non complaint with the smoking policy. Interventions included informing the resident, or responsible party, if applicable, regarding the center's smoking rules, designated smoking areas, and storage of smoking materials. An additional intervention was to keep oxygen away from smoking materials and to ensure removal prior to the resident smoking. Review of the physician order initiated 04/11/24 and discontinued 02/21/25 revealed Resident #11 received oxygen at 4 liters via nasal cannula (NC) continuously. Review of a progress note dated 08/05/24 revealed the Administrator, the DON, [NAME] Unit Manager #310, and Social Services Director (SSD) #307 met with Resident #11 and her husband for a care conference. Further review revealed Resident #11 had been found vaping in her room on more than one occasion recently and had been asked to stop. Resident #11 had signed the smoking policy and was aware of the smoking guidelines. The Administrator went over the smoking policy one more time and alerted Resident #11 and her spouse to not bring anymore vape pens into the facility. Resident #11 stated her understanding but stated she was probably not going to do what she was asked. The Administrator notified Resident #11 if she was noncompliant again, they would need to discuss finding a more appropriate facility. Resident #11 and her spouse voiced understanding. Review of the current physician order dated 02/26/25 revealed Resident #11 received oxygen at 4 liters via NC continuously. Review of a nursing progress note dated 04/21/25 at 7:42 P.M., written by RN #201, revealed Resident #11 was observed smoking a vape pen in her bedroom while her husband was present. Resident #11 had been told by multiple staff members about not smoking in the room. Review of the Smoking Evaluation, completed 04/25/25, revealed Resident #11 was able to smoke independently. Observation and interview on 06/05/25 at 8:14 A.M. revealed Resident #11 sitting in her wheelchair with oxygen via NC running at 3.5 liters per minute. Resident #11 stated she vaped in her room and when she vaped, she did not remove her oxygen. Resident #11 stated she was aware she violated the facility policy when doing so. Resident #11 asked the surveyor not to say anything to the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation and interview on 06/05/25 at 9:02 A.M. with Resident #11 revealed the vape pen was in a plastic tote container on her overbed table directly within reach. Resident #11 again asked the surveyor not to say anything because Resident #11 stated she would Get in trouble. Interview on 06/05/25 at 9:09 A.M. with Certified Nursing Assistant (CNA) #102 revealed she was aware Resident #11 kept a vape pen in her room. CNA #102 stated she never observed Resident #11 smoking the vape pen. CNA #102 stated she was aware staff removed the vape pen from Resident #11's room and Resident #11's husband would bring another one in for her. Telephone interview on 06/05/25 at 9:45 A.M. with RN #201 confirmed she wrote the progress note dated 04/21/25 regarding Resident #11 vaping in her room. RN #201 confirmed Resident #11 was wearing oxygen at the time of the observation. RN #201 stated she removed the vape pen from the room and placed it with the other locked smoking items. RN #201 stated Resident #11's husband would bring another vape pen when he visited and leave it with Resident #11. RN #201 stated she observed Resident #11 smoking her vape pen in her room with oxygen running on more than one occasion. Interview on 06/05/25 at 10:57 A.M. with Licensed Practical Nurse (LPN) #202 confirmed she observed Resident #11 smoking her vape pen in her room while receiving oxygen via NC sometime in September 2024. Interview on 06/05/25 at 11:15 A.M. with the Administrator confirmed residents were not allowed to keep vape pens in their rooms. Observation on 06/05/25 at 11:27 A.M. revealed a No Smoking sign on Resident #11's doorframe visible from the hallway. Telephone interview on 06/05/25 at 12:16 P.M. with Resident #11's husband revealed the facility had not taken Resident #11's vape pen away in a while and further confirmed he would bring her vape pens. Further, Resident #11's husband was aware Resident #11 was supposed to turn in her vape pen and was not turning it in to nursing staff. Interview on 06/05/25 at 3:23 P.M. with Director of Environmental Services (DES) #305 revealed she conducted Concierge Rounds daily with Resident #11 for approximately the last four weeks. DES #305 stated she visited Resident #11 to check on her and assist Resident #11 with any concerns. DES #305 confirmed Resident #11 had a vape pen on her bedside table every day. DES #305 stated she educated Resident #11 regarding the facility's policy regarding vape pens being kept in the medication room. DES #305 further stated Resident #11 refused to give her vape pen to DES #305. Review of facility policy titled Smoking Policy, revised 09/2022, revealed resident smoking materials will be retained and distributed by the facility staff to the residents during the designated smoking times and/or when independent resident chooses to smoke. Further review revealed electronic smoking devices and vapor products are to be considered the same as smoking. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of an article posted on the National Institutes of Health (NIH) website, pmc.ncbi.nlm.nih.gov/articles/PMC4390016/, titled E-cigarette Use In Patients Receiving Home Oxygen Therapy, published in 2015, under the heading of Hazards of E-cigarettes in Current Smokers: The basic components of most disposable or rechargeable e-cigarettes include a cartridge containing a liquid solution of propylene glycol (with or without nicotine), a battery and a heating element. This latter component reaches high temperature and aerosolizes the e-liquid to be inhaled. Consequently, it can conceivably ignite in the presence of oxygen. According to Public Safety Network (Agency for Healthcare Quality and Research), the use of any ignition source in the presence of oxygen is potentially hazardous. This issue was addressed specifically by the British Compressed Gases Association, which stated, electronic cigarettes are a potential ignition source and, in the context of oxygen-rich environments, have the same fire risks as traditional cigarettes. This opinion was supported by the Electronic Cigarettes Industry Trade Association, which agreed that in the context of oxygen use, it would be appropriate to describe electronic cigarette use as similarly hazardous to smoking. 2) Review of the medical record for Resident #12 revealed an admission date of 01/15/25. Diagnoses included multiple sclerosis, stroke, and anxiety. Review of the quarterly MDS assessment, dated 04/20/25, revealed Resident #12 had intact cognition. Review of the current care plan initiated 01/15/25, and revised on 03/04/25, revealed Resident #12 was resistant to care and non-complaint with smoking policy. The care plan revealed Resident #12 was a supervised smoker. Interventions included following and verbalized understanding regarding the facility rules for designated smoking areas and smoking material. Review of a nurse's progress note dated 03/02/25 revealed Resident #12 was found with a vape pen in her room. The nurse told Resident #12 if she wished to use the vape pen, she needed to go outside. Resident #12 told the nurse she would put the vape pen in her pocket. Review of the nursing progress notes dated 03/03/25 revealed SSD #307 and a CNA went to Resident #12's room to speak with the resident regarding vaping in her room. Resident #12 admitted to vaping in her room. SSD #307 explained vaping in the room was against the facility smoking policy. Resident #12 was pleasant, stated she understood, and handed over her vape pen to SSD #307. SSD #307 gave the vape pen to the DON to keep until Resident #12 discharged to home. Review of the Smoking Evaluation, dated 06/05/25, revealed Resident #12 was able to smoke independently. Observation on 06/05/25 at 8:41 A.M. revealed Resident #12 was lying in bed. A rechargeable vape pen was observed on her overbed table within reach. During a concurrent interview Resident #12 stated she did not smoke, but did use a vape pen. Resident #12 confirmed her vape pen was on her overbed table. Resident #12 stated she never smoked inside the facility and always went outside to use her vape pen. Resident #12 was aware she was not supposed to smoke in her room. Interview on 06/05/25 at 10:09 A.M. with CNA #103 confirmed she saw a vape pen on Resident #12's overbed table. CNA #103 stated she did not remove the pen but reported it to the night shift nurse and a Unit Manager. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 06/05/25 at approximately 11:21 A.M. with Resident #12 revealed she was not aware she was supposed to return her vape pen to nursing staff after she came back into the facility after using it. Interview on 06/05/25 at 2:01 P.M. with the Dietary Manager and Housekeeping and Laundry Supervisor (DMHLS) #308 revealed she was assigned to Resident #12 to provide daily Concierge Rounds. DMHLS #308 stated she observed the vape pen on Resident #12's overbed table while doing rounds on 06/05/25 at approximately 9:15 A.M. DMHLS #308 stated she educated Resident #12 to return the vape pen to staff when she finished using it. DMHLS #308 stated 06/05/25 was the first time she observed a vape pen in Resident #12's room. This deficiency represents non-compliance investigated under Complaint Number OH00166252.