STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366325	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ohio Veterans Home	3416 Columbus Ave Sandusky, OH 44870

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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35033 Based on review of the medical record, review of a police report, review of an incident report, observation, staff interview, and policy review, the facility failed to ensure a resident was adequately assessed for unsupervised smoking and failed to follow the smoking policy. This affected one (#84) of three residents reviewed for smoking safety. The facility identified 38 residents who smoked. The facility census was 223. Findings include: Review of the medical record revealed Resident #84 had an admitted [DATE] and a readmitted [DATE]. Diagnoses included paranoid schizophrenia, type two diabetes mellitus, osteoarthritis, anxiety disorder, depression, unspecified psychosis, insomnia, and polyneuropathy. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had impaired cognition. The resident required supervision for walking and was independent in wheelchair. Review of the care plan initiated 10/29/23 for Resident #84 revealed the resident had schizophrenia with potential for delusions and hallucinations. Interventions included administering medications as ordered and monitoring for adverse effects and effectiveness of medications, to monitor and record episodes of hallucinations or delusions, and psychiatric consults as ordered. Further review of the care plan revealed Resident #84 had episodes of agitation raising voice and yelling at staff. Interventions included to immediately intervene if altercation with another resident, notify physician as needed, one to one visits as needed, find cause of agitation and rectify, encourage resident to vent feelings. Review of a physician order dated 01/31/24 revealed an order for oxygen two liters per minute per nasal cannula, if using oxygen mask adjust flow meter to at least five liters per minute for pulse oximeter of less than 88 percent as needed for shortness of breath. Review of a physician order dated 10/24/24 revealed the resident had order for quetiapine 25 milligrams (mg), one tablet by mouth in evening for insomnia and schizophrenia. Review of psychiatric progress notes dated 11/21/24 revealed the resident had been taken off most of his psychiatric medications due to a physical illness. The resident had recovered physically and had more mental health signs and symptoms. The nursing staff stated the resident had become more paranoid and agitated. The resident was started on quetiapine 25 milligrams (mg) daily after last visit. The resident denied hallucinations and paranoid beliefs at the time of the visit. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a nurses note dated 12/31/24 at 7:55 A.M. revealed Resident #84 had hallucinations. The resident's antipsychotic medication quetiapine was increased to 50 mg at bedtime. Review of a psychiatric progress note dated 01/09/25 revealed nursing had reported increased paranoia and agitation in the resident. The resident denied paranoia and hallucinations at the time of the visit. The resident was noted as more stable on quetiapine and to continue current medications. Review of social service progress note dated 01/15/25 revealed the resident requested a carton of cigarettes. The social worker asked the resident what made him decide to smoke and the resident replied he used to smoke and missed it. Review of a nurses note dated 01/16/25 at 7:16 A.M. revealed the resident pulled out his indwelling urinary catheter and yelled at nurse it was not needed and refused to have it replaced. Review of a physician order dated 01/16/25 at 11:35 A.M. revealed Resident #84 was an unsupervised smoker. Review of a smoking assessment dated [DATE] at 11:36 A.M., revealed the resident smoked in the designated smoking area and displayed safe smoking. Further review of the smoking assessment revealed the assessment evaluated the functional ability to smoke. The smoking assessment form had not indicated if other pertinent safety factors were evaluated including medical conditions (i.e. oxygen use), mental health symptoms, and cognition level before determining if a resident required supervision or no supervision while smoking. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a police report dated 01/16/25 at 1:15 P.M. revealed Housekeeper #250 reported a fire in an auditorium on the second floor. Staff #260 reported exiting his office and noticing a small flame in the auditorium as Resident #84 was exiting the room. Housekeeper #250 grabbed a fire extinguisher while Staff #260 grabbed the bin with flames and carried to the open area in the room. Staff #260 stated the fire was put out using the fire extinguisher. Video footage was later observed and confirmed Resident #84 entered the auditorium at 1:07 P.M. in his wheelchair. Resident #84 proceeded to a table with tissues and blew his nose. Resident #84 then removed five tissues from the box then wheeled to the pool table and scattered the balls on the table. Resident #84 then went to the north corner of the room touching items on the shelf with his back to the camera. At 1:11 P.M. Resident #84 turns and looks around the room. At 1:12 P.M. a small fire flames/illuminating light appeared near the area the resident was located. Resident #84 placed a tissue that was lit on fire into the bin. Smoke was observed in the air. Resident #84 placed what was believed to be tissues on the shelf where the flame was located. At 1:13 P.M. Staff #260 entered the auditorium noticed the flames, requested a fire extinguisher from Housekeeper #250 who was walking by. Staff #260 confronted Resident #84 who threw his hands in the air saying he does not know what happened as he exited the room. Staff #260 picked up and carried the bin with flames to an open area. Housekeeper #250 brought a fire extinguisher and Staff #260 used the extinguisher to put the fire out. The police were called and the fire department was notified. There was very little property damage. The police asked Resident #84 for his cigarettes and lighter and the resident provided them. Resident #84 was interviewed and denied starting the fire even after watching the video and stated it was not me. The Administrator stated the resident would be placed on one-on-one staff supervision until he could be evaluated at the hospital. It was noted in the police report the resident had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 showing cognitive impairment. The resident's St. Louis University Mental Status (SLUMS) score was 16 out of 30 showing signs of dementia. The resident was also diagnosed with paranoid schizophrenia. Review of an incident report dated 01/16/25 at 1:29 P.M. revealed Resident #84 was not burned and had no injuries. The resident was burning items and witnessed by the police department on video surveillance. The resident's smoking materials were brought to the nurse by the police department. The resident was placed on one-one-supervision. Notifications were made to the physician, nurse practitioner, social worker, Administrator, Director of Nursing, and family. Review of a nurses note dated 01/16/25 at 1:29 P.M., revealed the police department was on the unit looking for Resident #84 for starting a fire in the auditorium with cards. Nurse took possession of the resident's cigarettes and lighter. Review of a progress note dated 01/16/25 at 1:55 P.M. revealed the resident set a fire and would now be a supervised smoker. Review of a progress note dated 01/16/25 at 2:25 P.M., revealed a BIMS was completed and the resident scored 11 out of 15 indicating cognitive impairment. Review of a social service note dated 01/16/25 at 2:47 P.M. revealed the social worker met with the resident. The resident denied starting a fire and stated he was playing pool. Resident continued to deny starting the fire even after he was told the incident was on camera. The social worker completed a slums assessment with the resident scoring a 16 out of 30 noting the resident had an eight grade education. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a progress note dated 01/16/25 at 3:06 P.M. revealed the physician approved of the resident on one-on-one supervision. Review of a social service note dated 01/16/25 at 5:12 P.M. revealed the resident agreed to go to the hospital for an evaluation for a psychiatric evaluation. Observation on 01/27/25 at 8:46 A.M. revealed there was a camera in the auditorium on the second floor. There were tables in the room and a pool table. Along the back wall there were shelves with books and activities like cards and puzzles. Further observation revealed no signs of fire, smoke or fire damage. Later observation of the grey plastic bin the fire was started in revealed the bin was melted on one end. Inside the bin were partially burned playing cards. Interview on 01/27/25 at 9:37 A.M., with the Administrator and Director of Nursing (DON) revealed after the fire incident on 01/16/25, the facility reviewed the smoking policy and smoking assessment with no changes made. Prior to the incident unsupervised/independent smokers could keep their lighters and cigarettes in their possession. The Administrator revealed staff were reeducated on the fire policy and smoking policy with new instructions to assess cognitive function using BIMS and SLUMS. Those with low scores were evaluated for supervised smoking. The Administrator revealed all smoking residents were reevaluated and all were now supervised while smoking. The DON revealed Resident #84 last used the as needed oxygen on 12/31/24. Further interview with the DON on 01/27/25 at 12:35 P.M. revealed she could not determine if Resident #84 had an oxygen concentrator in place for use on 01/16/24 when he was determined to be an unsupervised smoker in possessions of his cigarettes and lighter. The DON revealed the resident should not have had an oxygen concentrator in his room when he was allowed to have a lighter and cigarettes. Observation on 01/27/25 beginning at 10:40 A.M. in the designated smoking area outside the building revealed there were two extinguished cigarettes on the ground in the resident smoking area. Further observations revealed Resident #129 and Resident #40 were supervised by video surveillance while smoking. Licensed Practical Nurse (LPN) #300 had also been present in the smoking area. Registered Nurse (RN) #302 provided the residents with cigarettes and lit the resident's cigarettes. Interviews on 01/27/25 at 10:40 A.M., LPN #300 and at 10:43 A.M. with RN #302 each verified an extinguished cigarette was on the ground and had not been properly disposed of in the ash container. Further observation on 01/27/25 at 12:54 P.M., in Resident #84's room revealed there was an oxygen in use no smoking sign on the resident's door to the room. Resident #84 had no oxygen concentrator on his side of the shared room. Resident #84's roommate (Resident #12) had an oxygen concentrator on his side of the room and was ordered four liters of oxygen per nasal cannula continuous. Interview on 01/27/25 at 12:54 P.M., Certified Nursing Assistant (CNA) #200 verified Resident #84's roommate had an oxygen concentrator in the room and required continuous oxygen use. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/28/25 at 6:55 A.M., the DON revealed supervision for smoking was determined by the smoking assessment. The DON verified the smoking assessment form does not instruct the nurse to evaluate medical condition (i.e. oxygen use), mental health symptoms or cognition when determining if a resident was considered a supervised or unsupervised smoker. The DON revealed there was nowhere to document those things on the form. The DON revealed supervised smokers were not allowed to keep their cigarettes and lighter. Unsupervised smokers could always keep their own cigarettes and lighters with them. The DON revealed some residents just need supervision to get to and from the smoking area and were observed from a distance. Other residents required staff to be present with them. The DON revealed RN #490 had completed Resident #84's smoking assessment how the nurses were told to do it and the resident demonstrated safe smoking. The DON revealed RN #490 should have evaluated the resident's order for oxygen and discontinued the order if the resident was not using the oxygen. The DON revealed the resident was not on the radar for behavioral concerns. The DON revealed staff thought it was odd that Resident #84 wanted to start smoking and provided education to the resident about smoking. The DON verified the facility was not evaluating the residents' cognition at the time of the smoking assessment as stated in the smoking policy. The DON also revealed prior to the fire they had not been considering current medical conditions and a in determining supervision level. Interview on 01/28/25 at 7:08 A.M., RN #490 revealed completing the smoking assessment for Resident #84 on 01/16/25. RN #490 revealed a resident's supervision level was determined by the smoking assessment form and nothing else. RN #490 revealed Resident #84 had an order for oxygen but was not using it. RN #490 revealed the resident smoked safely, and knew where to go to smoke so he was an unsupervised smoker and was allowed to keep his cigarettes and lighter. RN #490 was not having any hallucinations at the time of the smoking assessment. Interview on 01/28/25 at 7:47 A.M. RN #492 revealed for a smoking assessment the resident was taken outside to smoke and observed for hand dexterity, not dropping ashes and distinguishing the cigarette in the bin. RN #492 revealed health conditions and mental health conditions were not considered when evaluating the resident's level of supervision needed. RN #492 revealed the smoking policy stated nothing in regard to medical conditions. Interview on 01/28/25 at 7:53 A.M., RN #494 revealed a function smoking assessment along with a resident's diagnoses, medical conditions, mental health issues and cognition were evaluated to determine if a resident was a supervised or unsupervised smoker. RN #494 revealed residents on oxygen could not have smoking materials. RN #494 revealed residents with hallucinations would need to be supervised especially if they are going through an adjustment period with medications. RN #494 revealed everyday something changes regarding smoking. RN #494 revealed the policy should be clearer and more direct with more training. RN #494 revealed the facility had not been proactive just reactive when something happens. Interview on 01/28/25 at 8:19 A.M., RN #496 revealed the smoking assessment form was used to determine if a resident needed supervision while smoking. RN #496 revealed we check if the resident can hold and dispose of the cigarette. RN #496 revealed some need direct one on one assistance and some were just watched through a camera but we should be a little closer. RN #496 revealed if a resident or the resident's roommate was on oxygen then the resident should not have a lighter. RN #496 revealed if a resident had an increase in delusions or hallucinations then they should not have a lighter or smoke unsupervised. RN #496 revealed the smoking policy was confusing and does not clearly state things. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/28/25 at 8:33 A.M., Registered Nurse (RN) #498 revealed smoking assessments were completed upon admission, readmission, and quarterly. RN #498 revealed they would observe the resident smoke. RN #498 revealed if the resident knew where to smoke, could hold, light, and ash the cigarette and where to extinguish the cigarette and not put on the ground then the resident was an independent smoker. RN #498 revealed she was not sure if a resident experiencing increases in mental health symptoms like delusions or hallucinations should be supervised or independent or have a lighter. RN #498 revealed previously she had not allowed one resident to keep his lighter because both his roommate and next door neighbor were on oxygen. RN #498 revealed the policy had some grey areas. RN #498 revealed after the fire the residents were now monitored more closely. Interview on 01/28/25 at 9:06 A.M., the Administrator revealed the facility was still in the process of evaluating the smoking policy and the smoking assessment forms as part of their performance improvement plan. Interview on 01/28/25 at 9:15 A.M., Licensed Social Worker (LSW) #600 revealed on 01/14/25 Resident #84 asked for cigarettes. LSW #600 revealed the resident was not a current smoker. LSW #600 revealed the resident stated he had smoked in the past and wanted a cigarette to smoke. LSW #600 revealed the cigarettes were purchased on 01/15/25 and given to the nurses on 01/16/25. LSW #600 revealed the resident had no alarming behaviors and she had not witnessed the resident having delusions or hallucinations. LSW #600 revealed after the fire she had evaluated the resident's cognition which was low which could be due to the resident's eighth grade education. LSW #600 further revealed Resident #94 denied starting the fire. Review of the policy Smoking, dated 02/02/24, revealed the provision of ashtrays but no direction to ensure cigarettes were extinguished in the provided ashtrays. No smoking signs would be maintained where oxygen was used. Resident who smoke would be assessed to determine if it was safe to smoke unsupervised using the assessment form. Smoking materials of supervised smoking resident would be maintained by the nursing staff. Unsupervised smokers could maintain smoking materials if stored safely and only used in designated smoking areas. All resident's on oxygen would be supervised smokers. If a resident who smokes experiences any decline in condition or cognition, they would be reassessed for ability to smoke and/or evaluate whether any additional safety measures were required. Documentation/information to support decision making of the assessment would be included in the medical record including assessment of relevant functional and cognitive factors affecting ability to smoke safely. Further review of the policy revealed no guidelines if an unsupervised smoker was allowed to maintain smoking materials if there roommate was on oxygen. Review of the policy Oxygen Safety, revised 03/18/24, revealed No Smoking signs would be used to identify oxygen in use and would remain in place until oxygen administration had been discontinued. No smoking rules would be strictly enforced while oxygen was in use including the removal of smoking materials from resident receiving oxygen. This deficiency represents non-compliance investigated under Complaint Number OH00161827.