

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/17/2025
NAME OF PROVIDER OR SUPPLIER  Glenburnie Rehab & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1901 Libbie Ave Richmond, VA 23226	

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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</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> Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to thoroughly investigate the circumstances surrounding a fire and to implement interventions to prevent future fires for a census of 116 residents. This resulted in a determination of Immediate Jeopardy (IJ). After Immediate Jeopardy was removed, the scope and severity were lowered to a level 2, widespread.</p> <p>The findings include:</p> <p>On 12/30/24, staff observed a burn smell in Resident #1's (R1's) room and observed the resident with a lighter. On 1/1/25, R1's roommate (R6) reported he extinguished a fire on his mattress. Staff observed a burn area on the lower right side of R6's mattress and some burn spots on the privacy curtains. The facility investigation determined it was highly probable that R1 started the fire. On 3/28/25, staff observed a toilet tissue roll in R1's bathroom was on fire. Since the 1/1/25 incident, the facility staff failed to conduct a thorough investigation into how R1 obtained materials to start the fires, and the facility staff failed to implement current and consistent interventions to prevent future fires and maintain safety for R1 and all other residents. These interventions include monitoring R1 and his room for fire starting materials, and lock boxes for all residents who are deemed safe to retain their smoking materials. Per staff interview, staff members did not understand the need to monitor R1 and his belongings. Also, per observation, resident interview, and other facility documentation, some residents did not utilize lock boxes for their smoking materials.</p> <p>R1's comprehensive care plan, dated 6/19/24 documented, The resident has behaviors. Resident ambulates to other resident's [sic] rooms and collect [sic] items. Resident is at risk for safety concerns related to fire due to collecting and attempting to use smoking devices or lighter. Wandering.</p> <p>On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/20/25, the resident scored 4 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely cognitively impaired for making daily decisions.</p> <p>A review of R1's clinical record revealed a nurse's note dated 12/30/24 that documented, Type of Behavior: burn smell observed in room, staff in to assist resident observed with a lighter staff checked room no more lighters observed, and no burning articles observed. Non-pharmacological intervention: education. Effect: effective at the time. PRN (as needed) Medication: na (not applicable). Outcome: left vm (voicemail) for rp (responsible party) and notified MD (medical doctor) per md to monitor oncoming nurse aware</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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>A nurse's note dated 1/1/25 documented, This writer was notified by cna (certified nursing assistant) on the floor stating that a 'fire was in the resident's room' This writer attended the room, and resident was there near his bed on the side of the window in standing position. No observation of fire nor smoke filled room observed. This writer asked, 'What happened?' and the resident gave no response just shrugged his shoulders. This writer questioned resident 'Did he have a lighter?' Resident's response was if I give it to you will you give me my lighter back? This writer responded 'No' Resident was asked 'May we search your person, and your personal belongings' Resident allowed his personal area to be checked for fire materials and even assisted by opening the drawers to the dresser/nightstand, but no fire materials was found. Resident allowed his clothing pockets to be checked and again no fire materials such a [sic] matches, cigarette lighter etc., was found. Resident was asked 'Are you okay?' and resident responded with 'I'm fine'. Resident's room was inspected for fire materials with his consent in which none was found on him nor in his personal belongings. Denied pain or discomfort., Resident was assessed for respiratory distress, and he was not observed to have a cough nor SOB (shortness of breath). Skin integrity remained intact. VS (Vital signs) 130/72 (blood pressure)-97.7 (temperature)-80 (pulse)-18 (respirations)-98% RA (oxygen level on room air) Director of Nursing notified.</p> <p>A note signed by the nurse practitioner on 1/2/25 documented, (R1) was seen this morning in his semi-private room at (name of facility). (R1) is reported to have had burned thing in his room and neither him nor his roommate could report how the curtain got burned. (R1) does not have any visible burns. He does not recall events. The note failed to document interventions to prevent future fires.</p> <p>An initial facility synopsis of events submitted to the SA (state agency) on 1/2/25 documented, Incident date: 01/01/2025: Resident (R1) was observed with a lighter, resident set the mattress and privacy curtain on fire in his assigned room. Roommate was not in room during the incident. There are no injuries to report .</p> <p>A psychiatry evaluation dated 1/7/25 documented, This is a [AGE] year-old male with history of depression and dementia. He was last seen by this provider on 12/10/2024 and no changes were made to his psychotropic medications. This is a consultation at the request of staff because patient was involved in setting a fire in his room. He is met in the common room today participating in an activity. He is on 1:1 (one-on-one supervision) because of his recent behaviors. However, it is unknown how his [NAME] [sic] curtain got burned. Patient stated that he does not smoke, and he does not have any lighter. He also stated that he has no intention to burn this place, and he does not have a clue about his curtain burning . Recommendations: 1:1 per facility protocol, may discontinue in 24 hours and do q (every) shift safety checks. Regularly inspect personal belongings and room for any flammable materials. Redirection. Offer opportunities for socialization and participation in activities as tolerated to avoid social isolation. Monitor for changes in mood or behaviors and notify/page (name of psychiatry company) as needed. Will continue to follow and provide consultation .</p> <p>A final facility synopsis of events submitted to the SA on 1/7/25 documented, This letter serves as the final report of the comprehensive investigation into the Facility Reported Incident initially filed on January 1, 2025, regarding an incident resulting in a fire involving residents in room (number) (R1) and (R6).</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 - Many</p>	<p>(R1) (room number) is a [AGE] year-old male initially admitted to the facility on [DATE] with a BIMS of 04. (R1) has diagnoses of vascular dementia without behavioral disturbance, dysphasia (difficulty to produce and comprehend verbal language), cognitive communication deficit, muscle weakness, atrial fibrillation (a heart condition), chronic pain, alcohol cirrhosis of the liver, delusional disorders, retention of urine, mild neurocognitive disorder, immunodeficiency, peritonitis (inflammation of the abdomen), acute and gastric ulcer.</p> <p>(R6 [R1's roommate]) (room number) is a [AGE] year-old male admitted to the facility on [DATE] with a BIMS of 15 (indicating the resident was cognitively intact). (R6) has diagnosis of adult hypertrophic (a narrowing of the opening of the stomach to the small intestines), gastrostomy (feeding tube), a neurocognitive disorder with Lewy Bodies, chronic obstructive pulmonary disease (lung disease), severe protein-calorie malnutrition, hemiplegia (paralysis) and hemiparesis (muscle weakness), sequelae of the cerebral infarction (long term effects from a stroke), orthostatic hypotension (a drop in blood pressure), PTSD (post-traumatic stress disorder), cardiac pacemaker, TBI (traumatic brain injury), and gastro-esophageal reflux.</p> <p>On January 1, 2025, (LPN [licensed practical nurse] #6), LPN verbally reported to the Administrator that Resident (R1) was observed with a lighter; Resident set the mattress and privacy curtain on fire in his assigned room. The roommate was not in the room during the incident, there were no injuries to report.</p> <p>Investigation</p> <p>-During an interview with (R6) (room number), with BIMS 15, he stated that at about 6pm on 1/1/25, he was at the nursing station trying to call his wife. After unsuccessful attempts to reach his wife, he decided to return to his room. When he arrived at his room, he noticed his bed was on fire. He balled up some sheets that were at the foot of his bed and used them to put out the fire. He stated that he shouted 'Fire! Fire!' and staff immediately came to his room but arrived when the fire was already out. He does not know how and what started the fire. He denied smoking or having a lighter.</p> <p>-The resident in (room number) (R1) was interviewed. He denied having a lighter and stated that there was no fire. (R1) has a BIMS of 05 and does not recall seeing or lighting a fire. (R1) has a history of wandering and socializing with other residents in the day room, including residents that smoke. He also has a smoking history but stated he stopped smoking about 7 months ago. Although (R1) denies smoking or having a lighter, staff confiscated a lighter from him on 12/30/24. Staff were unable to find any other lighter in his possession after a consented room search. However, the possibility of (R1) getting [sic] lighter from elsewhere cannot be undermined based on his history of wandering and socializing with visitors and other residents.</p> <p>-A statement was obtained from the CNA (certified nursing assistant), (CNA #5), who first heard and responded to the incident. (CNA #5) stated that at about 6:30pm, she was picking up meal trays from rooms in the 200 hallway when she heard (R6) screaming Fire! Fire! (CNA #5) immediately called the other CNAs (CNA #6 and CNA #7) and the nurse (LPN #7) to the room. When they arrived at the room with a fire extinguisher, there was no fire or smoke in the room. (R6) stated to them that his bed was on fire, and he put the fire out. They noticed a burn area on the lower right side of (R1's) mattress and some burn spots on the privacy curtains. Both residents were removed from the room per recommendation of the charge nurse, (LPN #7). The CNA and the nurse searched the room and found a lighter on (R6's) pants that was on his bed.</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 - Many</p>	<p>Based on the above findings, the burn area on the mattress in (room number) indicates that there was a fire in the room. Because no electrical malfunctions were noted upon bed inspection, and a lighter was found on the bed, it is highly probable that (R1) may have started the fire in the room. (R1) was the only one present in the room when the fire started, no other resident was observed going into room (number), and a lighter had previously been confiscated from him. He is also unable to recall that there was a fire in his room due to his cognitive status. The facility has provided lock boxes to residents who smoke to store their smoking devices to prevent residents with wandering behaviors from accessing them. The facility staff education on RACE (Rescue, Alert, Confine, Extinguish) has been initiated. The synopsis failed to document a thorough investigation of how R1 obtained fire starting materials.</p> <p>A progress note with an effective date of 1/14/25 and signed by the physician on 1/16/25 documented, Mild vascular dementia without behavioral disturbance, psychotic disturbance, mood disturbance, or anxiety. Attempted Moca (Montreal cognitive assessment) to gather baseline. Had difficulty understanding/following instructions. Will re attempt at future date. Regarding his dementia, there was also an incident a few days back when he was found with a lighter, I discussed this incident with him, and he had no acknowledgement of that situation. He is pleasant but mobile and walks around the facility all day. No behavioral risk to self or others that is intentional. He denies SI/HI (suicidal/homicidal) ideations today. The note failed to document interventions to prevent future fires.</p> <p>A facility synopsis of events dated 1/28/25 regarding another resident (R5) documented that the resident (who smoked) was not properly using his lock box. The report was regarding missing money and documented, On January 24, 2025, the resident reported to the unit manager that \$20 had gone missing from his lockbox, which is located in the top drawer of his dresser. The resident stated that he had placed \$22.00 in his lockbox the previous evening and had left the lockbox on top of his dresser with the key inside it. When he awoke the next morning, he noticed that his lockbox was turned upside down, and only \$2.00 was left inside.</p> <p>Further review of R1's clinical record revealed a note signed by the nurse practitioner on 3/11/25 that documented, Current somewhat stable functional status includes: Ambulatory with equal strength, oriented x 1, and mostly pleasant. Functional in most ADLs (activities of daily living) and conversational. FAST dementia scale 3-4. Unable to complete MoCa (Montreal cognitive assessment) due to inattention. Requires 24/7 supervision as he is dangerous with a lighter or cooking. Wander guard (a device to prevent residents from exiting the building) in place.</p> <p>A facility synopsis of events dated 3/14/25 regarding another resident (R4) documented that the resident (who smoked) was not using her lock box. The report was regarding a missing wallet/money and documented, Although (R4) has a lockbox [sic] at her bedside, she does not use it, preferring to hide her belongings under her pillow or beneath her bed.</p> <p>Further review of R1's clinical record from 1/9/25 through 3/28/25 failed to reveal the resident or resident's room was inspected for fire starting materials.</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 - Many</p>	<p>A nurse's note dated 3/28/25 documented, Resident is alert and oriented x2. Skin is dry to the touch. After dinner, resident took his medications as ordered. After dinner around 2030PM (8:30 p.m.) a CNA alerted this nurse of fire sand [sic] smoke coming from this residents [sic] restroom. Resident was removed to a safe location to be assessed. No S/S (signs or symptoms) of smoke inhalation, coughing, no SOB (shortness of breath), and no skin issues. DON (director of nursing) and RP (responsible party) notified.</p> <p>An initial facility synopsis of events submitted to the SA on 3/28/25 documented, Incident date: 3/28/2025. Residents involved: (R1) (R2). Resident [R1] lit a roll of toilet paper on fire in his bathroom. Staff extinguished the fire with water and dropped the paper roll in the toilet. Fire department alert [sic] and arrived to building.</p> <p>A psychiatry evaluation dated 4/1/25 documented, This is a [AGE] year-old male with history of depression and dementia. He was last seen by this provider on 2/18/25 at that time no changes were made to his psychotropic medications. This is a consultation at the request of staff due to patient's increased behaviors in the last week with symptoms that includes starting a fire in his bathroom, refusal of care and treatment, resistance, agitation, increased confusion and anxiety, difficult to redirect. He has been place [sic] on 1:1 per facility protocol. A medical work-up showed bacterial infection and he is currently on antibiotics. Patient is met in his room today, with flat affect. He did not recall the fire incident. He also does not recall his behaviors. There is no evidence that he responds to internal stimuli. He is directable at this time . Recommendations: May discontinue 1:1. Continue q (every) shift safety checks for 24 hours or per facility protocol. Regularly inspect personal belongings and room for flammable materials. Staff to continue to provide appropriate non-pharmacological measures as needed to manage disturbances in mood and behaviors such as redirection, reinforcement and distraction. Continue to offer opportunities for socialization and participation in activities as tolerated to avoid social isolation. Monitor for acute changes in mood or behaviors and notify/page (name of psychiatry company) as needed. Will continue to follow and provide consultation.</p> <p>A note signed by the nurse practitioner on 4/4/25 failed to document information regarding the 3/28/25 incident or interventions to prevent future fires.</p> <p>A final facility synopsis of events submitted to the SA on 4/4/25 documented, This letter serves as the final report of the comprehensive investigation into the Facility Reported Incident initially filed on March 28, 2025, regarding a fire incident in the bathroom of room (number) involving a resident, (R1).</p> <p>(R1) (room number) is a [AGE] year-old male initially admitted to the facility on [DATE] with a BIMS of 04. (R1) has diagnoses of vascular dementia without behavioral disturbance, dysphasia, cognitive communication deficit, muscle weakness, atrial fibrillation, chronic pain, alcohol cirrhosis of the liver, delusional disorders, retention of urine, mild neurocognitive disorder, immunodeficiency, peritonitis, acute and gastric ulcer.</p> <p>On 3/28/2025 at approximately 2030 (8:30 p.m.), staff reported to the Administrator that (R1) have [sic] started a fire in room (number) and that smoke was observed coming from the bathroom of room (number) that immediately triggered the fire alarm and the sprinklers. (R1) was out of the room when staff noticed the fire and his roommate, (R2) was immediately removed from the room with no injuries. The fire was quickly extinguished by staff before the arrival of the fire department. The facility Administrator initiated an investigation into the incident on 3/28/25.</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 - Many</p>	<p>-The DON assigned staff to conduct room search of all residents with wandering tendencies to verify there was no lighter in the room.</p> <p>-The DON assigned staff to complete 100% room search in the facility to verify no lighter is accessible to residents with wandering behaviors.</p> <p>-The Administrator held an emergency Resident Council Meeting to emphasize safe smoking practices and proper/discreet storage of all smoking-related items. The residents in attendance were educated on not sharing their cigarettes and lighters with other residents. Residents who smoke have been educated on the importance of lock boxes and how to use them.</p> <p>Based on the above findings, the fire incident in (R1 and R2's) room is substantiated. Because no electrical malfunctions were noted upon room inspection and no lighter was found on (R1), the source of the fire could not be fully determined. However, because (R1) was in the room prior to the incident and has a history of using smoking devices in the room, the facility is implementing measures to ensure (R1), and other residents with wandering behaviors do not have access to lighters. (R1) has been moved to a room closer to the nursing station for increased visibility and monitoring. An Ad-hoc QAPI (quality assurance and performance improvement) meeting was held on 3/31/25 to discuss safety of residents in the facility . The synopsis failed to document a thorough investigation of how R1 obtained fire starting materials.</p> <p>Further review of R1's clinical record from 4/4/25 through 4/15/25 failed to reveal the resident was provided with increased supervision or the resident/resident's room was inspected for fire starting materials.</p> <p>On 4/15/25 at 10:48 a.m., 4/15/25 at 11:40 a.m., and 4/16/25 at 8:48 a.m., R1 was observed unsupervised in the bedroom. On 4/15/25 at 3:59 p.m., and 4/15/25 at 4:16 p.m., R1 was observed wandering in the hall.</p> <p>On 4/15/25 at 11:08 a.m., an interview was conducted with R7 (a resident who smoked). The resident stated staff has never asked if another resident has asked for a lighter or attempted to take his lighter.</p> <p>On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/20/25, R7 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions.</p> <p>On 4/15/25 at 11:12 a.m., an interview was conducted with R8 (a resident who smoked). The resident stated staff has never asked if another resident has asked for a lighter or attempted to take his lighter.</p> <p>On the most recent MDS, a quarterly assessment with an ARD of 2/5/25, R8 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  Glenburnie Rehab & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1901 Libbie Ave Richmond, VA 23226	

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>On 4/15/25 at 11:15 a.m., an interview was conducted with R4 (a resident who smoked). R4 stated she does not use a lock box, and she hides her belongings in her room. R4 further stated staff has never asked if another resident has asked for a lighter or attempted to take her lighter. A lock box was observed under R4's bed. The box was open with the key in the lock.</p> <p>On the most recent MDS, a quarterly assessment with an ARD of 3/16/25, R4 scored 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions.</p> <p>On 4/15/25 at 11:23 a.m., an interview was conducted with OSM (other staff member) #2 (a housekeeper). OSM #2 stated administration staff has never asked her questions or provided education regarding R1.</p> <p>On 4/15/25 at 11:24 a.m., an interview was conducted with CNA #1 (hired in March 2025). CNA #1 stated she had heard a resident started a fire in a room, but she did not know who the resident was and was not provided education.</p> <p>On 4/15/25 at 11:30 a.m., an interview was conducted with CNA #2. CNA #2 stated she was aware R1 had started fires and interventions that were implemented when the incidences occurred (such as safety checks and inspecting the room for lighters). CNA #2 stated she has never been asked questions about how R1 was obtaining lighters she did not know if any interventions were currently being implemented.</p> <p>On 4/15/25 at 11:36 a.m., an interview was conducted with LPN #2 (the nurse caring for R1). R1 stated she has never been asked questions about how R1 was obtaining lighters. LPN #2 further stated she was not aware of any instructions to inspect R1 or the resident's room, but staff had been taking lighters from the resident when they found them.</p> <p>On 4/15/25 at approximately 2:00 p.m., an interview was conducted with CNA #3 (the CNA caring for R1). CNA #3 stated she did not know anything about facility fires. CNA #3 stated R1 was confused, and wanders and she has never been provided instructions to inspect R1 or the resident's room for lighters.</p> <p>On 4/15/25 at 3:31 p.m., an interview was conducted with LPN #5. LPN #5 stated she did not remember the interventions that were implemented for R1 after the fire incidents in January 2025 and March 2025.</p> <p>On 4/15/25 at 4:02 p.m., an interview was conducted with LPN (licensed practical nurse) #8 (the nurse caring for R1). LPN #8 stated she was not aware of any interventions involving R1 and lighters. LPN #8 stated she was not aware if R1 required increased supervision, and she was not aware if she needed to inspect R1 or the resident's room for lighters.</p> <p>On 4/16/25 at 11:33 a.m., an interview was conducted with ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing). ASM #1 stated that after the 1/1/25 fire, the staff implemented lock boxes for residents who smoke, and staff tried to figure out how R1 obtained lighters because he frequently walks around and takes things. ASM #1 stated she did not include visitors in the fire investigations. ASM #1 further stated that a member of the IDT (interdisciplinary) team checks R1's room for lighters during the daily room rounds.</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 - Many</p>	<p>On 4/16/25 at 11:43 a.m., ASM #1 and ASM #2 were notified of Immediate Jeopardy.</p> <p>On 4/16/25 at 11:54 a.m., an interview was conducted with LPN #4 (the minimum data set coordinator). LPN #4 stated that members of the IDT team have certain groups of rooms they go into every day. LPN #4 stated, We look for things out of place. We look to see if there are lighters or anything lying around. We do this once a day. I went in [to R1's room] very early this morning. The time of day varies. LPN #4 provided room round forms for R1's room. The forms documented no lighters were found at the time of rounds and were dated 4/2/25, 4/3/25, 4/4/25, 4/7/25, 4/8/25, 4/9/25, 4/10/25, 4/11/25, 4/14/25, 4/15/25, and 4/16/25.</p> <p>On 4/16/25 at 1:27 p.m., an interview was conducted with RN #1. RN #1 stated R1 is alert and confused, oriented times one or two, and wanders on both units and into other resident rooms. RN #1 stated she has seen R1 take items that didn't belong to him from the common areas. RN #1 stated R1 spends a good portion of the day in the common area where a lot of visitors visit and where the smokers go outside. RN #1 stated staff should keep their eyes on R1 when he is in that area and staff should search R1, with the resident's consent, when the resident returns from other areas of the facility. RN #1 stated she informs nurses about R1 when she gives report but there was nothing specifically documented on the unit to alert staff.</p> <p>The facility presented the following IJ removal plan which was accepted on 4/16/25 at 6:45 p.m.</p> <p>Immediate Jeopardy Abatement Plan</p> <p>Date: 04/16/2025</p> <ol style="list-style-type: none"> <li>1. R1 was immediately placed on permanent 1-1 supervision, and the patient's room was thoroughly searched for smoking materials. No smoking paraphernalia was found; had any been discovered, it would have been immediately removed from the resident's room to mitigate further risk. Fire-damaged furniture and the mattress were replaced. Maintenance completed a full safety inspection, and (name of contractor) conducted an external fire inspection. Resident's care [plan] updated. The RP (responsible party) for R1 was contacted and educated about the dangers of providing smoking materials to residents deemed unsafe to retain such items.</li> <li>2. Current residents in the facility have the potential to be affected by the deficient practice. UM (unit manager) or a designee conducted a facility-wide search on April 16, 2025, to locate and remove all unauthorized smoking and fire-starting materials. The Director of Nursing or a Designee completed a 100% reassessment of smoking risk for all residents with a history of smoking to validate the accuracy of their smoking assessments and ensure proper safeguards are in place. All unsupervised smokers were assessed to determine their capacity to retain and securely store smoking materials.</li> <li>3. The SDC (staffing development coordinator) or designee[TRUNCATED]</li> </ol>		

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<p>F 0712</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that the resident and his/her doctor meet face-to-face at all required visits.</p> <p>Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide timely physician visits for one of nine residents in the survey sample, Resident #5.</p> <p>The findings include:</p> <p>For Resident #5 (R5), the facility staff failed to provide physician visits every sixty days.</p> <p>A review of R5's clinical record revealed physician visits on 4/22/24 and 7/16/24. The review revealed no physician visits between these two dates.</p> <p>On 4/22/25 at 8:45 a.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She most residents need to be seen quarterly, with the exception of residents receiving skilled nursing services. She stated the facility's providers are diligent about timely visits. She stated R5 saw two outside providers between 4/22/24 and 7/16/24 but was not seen by a facility physician.</p> <p>On 4/22/25 at 10:36 a.m., ASM #1, the administrator, was informed of these concerns.</p> <p>A review of the facility policy, Physician Visits, revealed, in part: Each patient will be seen by a physician upon admission .Patients will then be seen by a provider at least every 30 days for the first 90 days after admission, and at least every 60 days thereafter.</p> <p>No additional information was provided prior to exit.</p>

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>Based on staff interview and facility document review, the facility staff failed to post a complete record of nursing staffing for 30 of 30 days reviewed.</p> <p>The findings include:</p> <p>The facility staff failed to post an accurate daily nursing staffing sheet for 30 days in March and April 2025.</p> <p>A review of the facility staff posting sheets from 3/21/25 through 4/19/25 failed to reveal any resident census information for any of the three shifts on any of these 30 days.</p> <p>On 4/22/25 at 9:06 a.m., CNA (certified nursing assistant) #8 was interviewed. She stated she had been trained to calculate all the RN (registered nurses), LPN (licensed practical nurses) and CNA hours for each shift for each 24 hour period. She stated she had not been trained to fill out the census on each shift for each day.</p> <p>On 4/22/25 at 10:36 a.m., ASM (administrative staff member) #1, the administrator, was notified of these concerns.</p> <p>A review of the facility policy, Daily Nurse Staffing Summary, failed to reveal any information regarding the resident census for each shift.</p> <p>No additional information was provided prior to exit.</p>

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<p>F 0840</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service.</p> <p>Based on staff interview and clinical record review, the facility staff failed to evidence agreements for contractual services for one of one facility.</p> <p>The findings include:</p> <p>The facility staff failed to maintain agreements for services with the contracted podiatry company and contracted eye care company.</p> <p>A review of the facility contracts failed to reveal agreements for services with the contracted podiatry company and the contracted eye care company.</p> <p>On 4/22/25 at approximately 8:55 a.m., ASM (administrative staff member) #2 (the director of nursing) presented service agreements for a podiatry company and an eye care company. The agreements were dated 4/21/25 and were not signed by a facility representative.</p> <p>On 4/22/25 at 10:36 a.m., an interview was conducted with ASM #1 (the administrator). ASM #1 stated that when services are initiated with an outside company, she has the company sign an agreement and places the agreement in a contract binder. ASM #1 stated the facility began services with the podiatry company and eye care company before her employment at the facility.</p> <p>On 4/22/25 at 11:10 a.m., ASM #1 stated she was unable to locate the original podiatry and eye care contracts.</p> <p>The facility policy titled, Contracts/Agreements documented, All contracts and/or agreements that are initiated between the Health and Rehabilitation Center and any third-party provider and/or vendor must be approved by designated officers of the company prior to engaging in any contractual obligations and/or service .4. Contracts/agreements between the Health and Rehabilitation Center and the negotiating third-party are not valid unless signed by the appropriate officer of the company.</p> <p>No further information was presented prior to exit.</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>Based on staff interview and facility document review, the facility staff failed to implement an effective QAPI (quality assurance and performance improvement) program for one of one facility.</p> <p>The findings include:</p> <p>The facility staff failed to ensure their 3/28/25 QAPI plan regarding a fire incident was effective. The facility staff failed to ensure a resident who smoked utilized a lock box for her smoking materials and failed to ensure staff were knowledgeable regarding the education documented in the plan.</p> <p>An initial facility synopsis of events submitted to the SA (state agency) on 3/28/25 documented, Incident date: 3/28/2025. Residents involved: (R1) (R2). Resident [R1] lit a roll of toilet paper on fire in his bathroom. Staff extinguished the fire with water and dropped the paper roll in the toilet. Fire department alert [sic] and arrived to building.</p> <p>A QAPI plan dated 3/28/25 documented, PROBLEM: On 3/29/25 [sic] staff observed a fire in the bathroom of room (room number). F689. Immediate Response-what was done at the time. Both residents in the room were safely evacuated. The fire was immediately extinguished by staff and the code was cleared by the fire department. (R2) was moved to a different room. (R1) refused to move as there was no damage to the room. (R1) was placed on one-on-one supervision until cleared by psych because of history of attempting to use a lighter in the room. Pain, skin and respiratory assessments were conducted for both residents in the room. How to Identify other residents that might be impacted. Current residents in the center have the potential to be affected. The DON (director of nursing) or designee conducted a 100% room search to ensure all smoking paraphernalia are stored in lock boxes. Any lighter found outside the lock box shall be placed in a lock box and the resident educated on the need to use the lock box. The Administrator or designee held a safety committee meeting on 3/29/25 with residents who smoke to discuss the importance of ensuring that they use their lock boxes to store their smoking devices to prevent residents with wandering behaviors from having access to smoking paraphernalia. The DON or designee audited residents who wander, resident smoking assessments and care plans to identify need for locked boxes to prevent smoking paraphernalia and lighters being accessible to other residents. What Measures were put in place to prevent reoccurrence. The SDC (staffing development coordinator) or designee will educate facility staff on the processes for implementing interventions such as redirection/distraction to prevent residents with wandering behaviors from having access and/or obtaining lighters to prevent risk for igniting and causing fires. The DON or designee shall audit all residents who smoke to verify they have lock boxes to store smoking paraphernalia. How to monitor to ensure the problem does not reoccur. The DON or designee will complete weekly audits x 4 weeks of residents who smoke to verify they have lock boxes and are storing their smoking devices in the lock box. Findings will be corrected. The administrator or designee will audit weekly x 4 weeks and monthly x 2 residents with wandering behaviors to verify they do not have smoking paraphernalia. QA. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance is sustained. Once the QA Committee determines the problem no longer exists [sic], then review will be completed on a random basis.</p> <p>On 4/15/25 at 11:15 a.m., an interview was conducted with R4 (a resident who smoked). R4 stated she does not use a lock box, and she hides her belongings in her room. A lock box was observed under R4's bed. The box was open with the key in the lock.</p> <p>(continued on next page)</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On the most recent MDS, a quarterly assessment with an ARD of 3/16/25, R4 scored 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions.</p> <p>On 4/15/25 at 11:23 a.m., an interview was conducted with OSM (other staff member) 2 (a housekeeper). OSM #2 stated administration staff have never asked her questions or provided education regarding R1.</p> <p>On 4/15/25 at 11:24 a.m., an interview was conducted with CNA (certified nursing assistant) 1 (hired in March 2025). CNA #1 stated she had heard a resident started a fire in a room, but she did not know who the resident was and was not provided with education.</p> <p>On 4/15/25 at 11:36 a.m., an interview was conducted with LPN (licensed practical nurse) 2 (the nurse caring for R1). R1 stated she has never been asked questions about how R1 was obtaining lighters. LPN #2 further stated she was not aware of any instructions to inspect R1 or the resident's room, but staff had been taking lighters from the resident when they found them.</p> <p>On 4/15/25 at approximately 2:00 p.m., an interview was conducted with CNA #3 (the CNA caring for R1). CNA #3 stated she did not know anything about facility fires. CNA #3 stated R1 was confused, and wanders and she has never been provided instructions to inspect R1 or the resident's room for lighters.</p> <p>On 4/15/25 at 3:31 p.m., an interview was conducted with LPN #5. LPN #5 stated she did not remember the interventions that were implemented for R1 after the fire incidents in January 2025 and March 2025.</p> <p>On 4/15/25 at 4:02 p.m., an interview was conducted with LPN (licensed practical nurse) 8 (the nurse caring for R1). LPN #8 stated she was not aware of any interventions involving R1 and lighters. LPN #8 stated she was not aware if R1 required increased supervision, and she was not aware if she needed to inspect R1 or the resident's room for lighters.</p> <p>On 4/22/25 at 10:36 a.m., an interview was conducted with ASM #1 (the administrator). ASM #1 stated that she had not noticed the above QAPI plan was not effective.</p> <p>The facility policy titled, QAPI documented, The Administrator is responsible for directing the Center's Quality Assurance/Performance Improvement (QAPI) Plan that focuses on Center specific indicators that measure quality of care, quality of life and patient choice. The QAPI plan will systematically identify actual or potential areas of risk or deficiency and will proactively pursue ongoing performance improvement.</p> <p>No further information was presented prior to exit.</p>		