STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525338	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver Dam Health Care Center	410 Roedl CT Beaver Dam, WI 53916

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that all residents are clinically appropriate to self-administer medications for 1 of 1 resident (R1) reviewed for self-administration of medications.Nursing staff reported to Surveyor that R1 has a backpack full of medications. R1 does not have a completed self-administration of medication assessment.Evidenced by:The facility policy, Self-Administration of Medications, dated 10/24, states, in part;.In order to maintain the residents' high level of independence, residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self-administer.If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out this responsibility during the care planning process.R1 was admitted to the facility on [DATE] with a diagnoses including alcohol use, chronic pain, generalized anxiety disorder, insomnia, cerebral aneurysm, non-ruptured (a brain aneurysm, is a bulge or ballooning in a blood vessel in the brain), cocaine abuse, homelessness, major depressive disorder, persistent mood disorder, post-traumatic stress disorder, and restlessness and agitation.R1's most recent Minimum Data Set (MDS) dated [DATE], indicates R1 has a Brief Interview for Mental Status (BIMS) of 15 indicating R1 is cognitively intact. R1 is own person.On 3/4/26 at 9:00 AM, LPN E (Licensed Practical Nurse) indicated R1 has medications in her bedroom.On 3/4/26 at 9:20 AM, LPN D and LPN H indicated that R1 has a backpack with medications in it. Both LPNs indicated that R1 does not allow anyone to go through her backpack, so they do not know what medications are in there.Surveyor reviewed R1's care plan and orders. R1 has not been assessed and care planned to safely self-administer medications at this time.On 3/5/26 at 11:45 AM, DON B (Director of Nursing) indicated he is currently working on the self-administration for medications assessment for R1. DON B indicated there is currently not one. DON B indicated he first learned about R1 having medications in her room on 3/2/26.R1's progress notes states, in part;.3/5/26 10:49.DON B, Writer at bedside with resident who is willing to go through her medications that she has in her bag. Resident medications that she has include: Topiramate 100mg (milligrams), Tylenol 500mg, Ibuprofen 200mg, Vitamin C 500mg, Jet Alert, Vitamin D3 2000iu (international units), iron supplement 28mg, Docusate Sodium 100mg, Ashwaganda pills, and Fluoxetine 20mg.NP notified of resident medications. New orders to discontinue Topiramate, Tylenol, ibuprofen, and fluoxetine. Resident was made aware of potential interaction with Ashwaganda pills and fluoxetine as well as risks. Resident stated she understands and will not take the Ashwaganda pills anymore however still kept them on her person. NP (Nurse practitioner) notified. Writer discussed self-administration with resident who agrees with plan. NP notified of resident wanting to self-administrate and agrees with plan.On 3/5/26 at 4:50 PM, DON B, NHA A (Nursing Home Administrator), and CRN C (Corporate Registered Nurse) indicated understanding of the above concern.The facility did not ensure R1 was clinically appropriate to self-administer medications.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** Based on interview and record review, the facility did not ensure each resident receives adequate supervision to prevent accidents and hazards for 1 of 3 residents (R1) reviewed for safety.On 2/27/26, a resident (R1) who smokes started a fire in her room using a lighter that she was deemed safe to have in her possession. R1 was not reassessed for safety after igniting material in her room and continued to have smoking materials in her possession without safety interventions being put in place to ensure she does not start another fire within the building. Residents in rooms next to R1 use oxygen.The facility's failure to reassess R1 after she started a fire with smoking materials, and the failure to implement proper safety interventions to prevent accidents created a finding of immediate jeopardy that began on 2/27/26. Surveyor notified NHA A (Nursing Home Administrator), DON B (Director of Nursing), and CRN C (Corporate Registered Nurse) of the immediate jeopardy on 3/5/36 at 4:50 PM The immediate jeopardy was removed on 3/6/26; however, the deficient practice continues at a scope/severity of E (potential for more than minimal harm/pattern) as the facility continues to implement its action plan.Evidenced by:The facility policy, Resident Smoking, dated 2/4/26, states, in part: .Purpose: To provide a safe and healthy environment for residents, staff, visitors, and contractors by maintaining a smoke-free campus. This policy promotes resident safety, reduces fire risk, and supports public health initiatives.Smoking safety assessments will be completed quarterly and as needed with any change in condition or functional abilities.Cigarettes, cigars, lighters, matches, vaping devices, and all tobacco products must be turned in to the nurse for secure storage.Smoking materials are not permitted in resident rooms, on their person, or in their belongings while on facility property.smoking materials may not be shared with other residents at any time.Residents who choose not to provide the facility with their smoking materials must safeguard these items in a locked, secure container.failure to comply with this requirement may result in a 30-day discharge notice.R1 was admitted to the facility on [DATE] with diagnoses that include alcohol use, chronic pain, generalized anxiety disorder, insomnia, cocaine abuse, major depressive disorder, persistent mood disorder, post-traumatic stress disorder, and restlessness and agitation.R1's most recent Minimum Data Set (MDS) dated [DATE], indicates R1 has a Brief Interview for Mental Status (BIMS) of 15 indicating R1 is cognitively intact. R1 is her own person.R1's current care plan states in part:.initiated: 11/6/25, I sometimes have behaviors which include accusations, manipulation, inappropriately recording and calling the police inappropriately.I have behaviors which include going into staff only work spaces.I sometimes have behaviors which include being verbally aggressive with staff. Initiated: 12/24/25, I sometimes have hoarding behaviors which include excessive accumulation of items in resident room.Initiated: 1/16/26 I have made threats to staff that I will [NAME] them if they wake me up.Initiated: 1/25/26, I choose to safe keep my own smoking materials in my room. Resident will adhere to the tobacco/smoking policies of the facility.Conduct smoking safety evaluation on admission and PRN (as needed.) Educate resident/responsible party on the facility's tobacco/smoking policy. I will safe guard my smoking materials, I understand my smoking materials cannot be left out unattended to ensure the safety of my peers. If my smoking materials are left unattended, give the materials to the nurse for safe keeping. Offered smoking cessation, resident declined. Reviewed benefits but resident continues to decline at this time. R1's Smoking and Safety Assessment states in part: dated 1/25/26, Supervision, designated smoking location, and smoking times are determined by facility policy. This evaluation will be utilized for the resident's smoking care plan on admission and as indicated.Which of the following products does the resident use? Tobacco. Does the resident display any of the following? .Follows the facility's policy on location and time of smoking. Care Planning.Resident will adhere to the tobacco/smoking policies of the facility. Conduct smoking safety evaluation on admission and PRN. Educate (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident/responsible party on the facility's tobacco/smoking policy.It is important to note the facility did not complete an updated Smoking and Safety Assessment after the incident on 2/27/26 when R1 started a fire in her bedroom.R1's nursing progress notes state in part:.2/27/26 12:37.@925 (9:25 am) writer was pushing another resident down the hall and smelt smoke. Writer asked CNA (Certified Nursing Assistant) to check area where smoke was smelt. CNA altered [sic] writer to resident's room, upon entering room writer noted that resident had cut up an ace wrap and sheet and had started the material on fire. Material on floor was wet. Resident stated she put fire out. When asked why she started the fire, resident replied I don't know. I am not in my right mind. Administrator was updated. Staffed with resident until resident left facility.note written by LPN D (Licensed Practical Nurse).LATE ENTRY 2/27/26 12:13 (12:13 PM) .Staff notified NHA that resident ignited a small item in her room using a personal lighter. NHA immediately met with resident to assess the situation. Resident stated she used her lighter to burn something small near her shoe. Nursing staff reported the resident was observed burning additional small items and described the behavior as related to being all over the place. No injuries noted at time of assessment. Room checked for safety. Lighter removed from resident's possession. Given the discrepancy in reports and safety concern, social services to review resident's mental status with NP (Nurse Practitioner) and reassess cognition, including review of most recent BIMS. Resident placed on 15-minute safety checks. Ongoing monitoring initiated.note written by NHA A (Nursing Home Administrator)).R1's care plan indicated on 2/27/26, I sometimes have behaviors which include attempting to start a fire with my lighter. My behavior will stop with staff intervention. Administer meds as ordered. Monitor and document for side effects and effectiveness. Contact local law enforcement/NHA if behavior occurs. Discuss resident's behavior, explain/reinforce/educate why behavior is inappropriate/unacceptable. Give resident personal space. Intervene as necessary to maintain safety of resident or others. Monitor/document/report any signs of resident posing danger to self or others. Psychology/psychiatry consult as ordered.On 3/4/26 at 9:20 AM, Surveyor interviewed LPN D (Licensed Practical Nurse) and LPN H. LPN D indicated she was the nurse that was working down R1's hallway on 2/27/26. LPN D indicated it was around 9:00 AM on 2/27/26 when she smelled smoke. LPN D indicated she was walking with another resident and could smell smoke when they came out of the hallway. LPN D indicated it was a nice day and a window was open, so she thought maybe it was someone burning something outside. LPN D asked the two CNAs down the hallway to search all the bedrooms as she finished assisting the resident she was with. LPN D indicated the two CNAs started searching rooms. LPN D indicated one of the CNAs yelled down the hallway, R1 lit a fire in her room! LPN D indicated she observed the pile in R1's bedroom; it was a pile of ace wrap and pieces of a sheet. The pile was on the floor, burnt, and wet. LPN D reported R1 had put out the pile so it was wet. LPN D indicated management did not come down. LPN D indicated R1 told them she wasn't in her right state of mind and wasn't sure why she started the fire. LPN D indicated R1 was not in her bedroom, but was down the hallway, and went with the CNA to the Nursing Home Administrator's office. LPN D indicated the pile of burned up ace wrap and sheets was still in the same spot on R1's bedroom floor when LPN D came back to work on Monday morning. LPN D indicated R1 has a backpack full of medications, [NAME], and a knife. LPN D indicated the police were not called and staff were told to keep an eye on R1. LPN D indicated R1 still has smoking materials and has been going in and out smoking all morning. LPN D indicated after the incident they took her lighter, but currently she has her smoking material and manages it on her own. LPN D indicated the last two days they have been receiving education on the smoking policy and procedures. LPN D indicated shortly after the incident R1 left the facility and did not return until later that night. LPN D indicated it is R1's norm to leave the facility for the entire day. LPN D indicated she asked the Director of Nursing why the police were not called and he told her he would have to ask about that since he wasn't at the facility at the time of the incident. LPN H indicated agreement that R1 still has her smoking materials on hand and has been going in and out smoking. LPN H indicated this is their (nurse's) license on the line and they spend so much time trying to watch over some of (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the residents with challenging behaviors.On 3/4/26 at 12:40 PM, CNA K indicated she was the staff that was working down R1's hallway on 2/27/26. CNA K indicated it was around 9:00 AM and she had just been in R1's bedroom and asked R1 if she could help her organize her room. CNA K indicated R1 had her items all over the bedroom and was asking for boxes to pack up all of her items. CNA K asked R1 if she could help her clean up and R1 told her later. CNA K indicated she was standing by the nurses' station and LPN D said that she smelled something burning down the hallway. CNA K and CNA O started searching bedrooms. CNA K indicated she and the other CNA started going from room to room starting at the front of the hallway, and when they entered R1's room, which is at the end of the hallway, they could see the burnt pile and smelled smoke. CNA K indicated that R1 was not in her bedroom. CNA K indicated the pile was 3-5 steps in front of her sink in the bedroom, and the pile was ace wrap and something else all burnt up. CNA K stated it was covered in water and looked like it was just put out. CNA K indicated she and CNA O yelled down the hallway and then immediately went to the NHA's office. CNA K indicated R1 was down the hallway and followed them to the office. CNA K indicated they asked R1 if she started a fire in her room and she said that she did and it was on purpose. CNA K indicated R1 stated, We are all going to die anyways. CNA K indicated they found a knife, [NAME], and medications in R1's bedroom. CNA K indicated she gave the knife, [NAME], and lighter to the NHA. CNA K indicated it was a scary situation because you don't know exactly what R1 has in her bag and she was coming towards the CNAs with her hands in her pockets. CNA K indicated her top concern was everyone's safety and it was so much going on at that moment. CNA K indicated she reported all of this immediately to the NHA. CNA K indicated she received education and NHA talked to her about not taking items out of a resident's bedroom. CNA K indicated she got talked to because she took the knife and [NAME] out of R1's bedroom. CNA K indicated she took the items out of the bedroom because she needed to keep everyone safe. CNA K indicated it was a very stressful situation, and she didn't know what R1 was going to do next.On 3/4/26 at 2:40 PM, CNA O indicated she was the other CNA that was working down R1's hallway on 2/27/26. CNA O indicated LPN D asked if she smelled something burning and CNA O and CNA K searched bedrooms. CNA O indicated they found the pile of something burned on R1's floor and it was wet like it had been put out. CNA O indicated R1 wasn't in her room at the time and that they found her in the hallway. CNA O indicated they asked her if she started the fire and she said yes. CNA O indicated they asked her if she did it on purpose and she said yes. CNA O indicated they gave the knife and [NAME] to the administrator and reported everything immediately. CNA O indicated she hasn't worked at the facility since the 2/27/26 incident, but she has received education on the smoking policy multiple times.On 3/4/26 at 9:45 AM, NHA A (Nursing Home Administrator) indicated he immediately started education after the incident on 2/27/26 with R1. NHA A indicated he started education on the smoking policy/procedures, oxygen use, and all the education that was previously done. NHA A indicated they added smoking material on the Angel Rounds form as well and started a sweep to ensure the residents that do have their smoking materials are appropriately safeguarding them. NHA A indicated R1 left the building right after the incident, returned around 8:30 PM and was placed on 15-minute checks until R1 met with psych on 2/28/26. Surveyor asked NHA A for all documentation, education, assessments, 15-minute check forms, psych notes, and sweeps that were started after the incident on 2/27/26 to current. NHA A indicated understanding.On 3/4/26 at 9:00 AM, LPN E indicated she was working on 2/27/26 and co-workers down R1's hallway were searching for what smelled like smoke. LPN E indicated she heard that staff found items in R1's bedroom such as [NAME] and medications. LPN E indicated she watches to make sure R1 swallows her medications when she gives them to her because of medication concerns. LPN E indicated just this morning LPN E was offering pain medications to a different resident and R1 said, Oh, I'll take their pain medications. LPN E indicated she provided R1 education at that time.On 3/4/26 at 9:05 AM, CNA F indicated she heard about R1 starting a fire in her bedroom. CNA F indicated R1 had to turn in her lighter after the incident on 2/27/26. CNA F indicated she received education yesterday regarding smoking policy and procedures. CNA F indicated she is (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	not sure if R1 can have smoking materials in her room at this time but knows she has a lock box in her room.On 3/4/26 at 9:10 AM, CNA G indicated she heard about R1 starting a fire in her bedroom. CNA G indicated she received education on Monday and Tuesday regarding smoking policy, oxygen, and procedures. CNA G indicated R1 was on 15- minute checks after the incident. CNA G indicated R1 is very independent and has been at the facility for a few months now.On 3/4/26 at 12:20 PM, LPN I indicated she worked Sunday first shift. LPN I indicated R1 is very protective over her backpack and will not allow staff to go in it. LPN I indicated she remembers R1 going in and out of the building, doesn't know if R1 can have her smoking materials now after the incident, and that LPN I didn't go in R1's bedroom at all on her Sunday shift. LPN I indicated she has received education on the smoking policy recently. LPN I indicated she heard about the fire that R1 started in her bedroom but was not working that day.On 3/4/26 at 12:30 PM, CNA J indicated she has recently received education on the smoking policy after the incident on 2/27/26. CNA J indicated she was not down R1's hallway on 2/27/26, but CNA K and CNA O were working down the hallway.On 3/4/26 at 1:20 PM, CNA L indicated she was working the morning of 2/27/26. CNA L indicated she could smell smoke and observed the pile of burned ace wrap on R1's bedroom floor. CNA L indicated the pile was burned and was wet. CNA L indicated staff reported it to management and that was as much as she knew. CNA L indicated she went back to her daily tasks after it had been reported. CNA L indicated after the incident management reviewed the smoking policy and procedures with staff. CNA L indicated she also received the education on Monday when she worked.On 3/4/26 at 1:30 PM, CNA M indicated she received education on the smoking policy, oxygen, what to do if you see someone smoking/fire, and notifications on Monday. CNA M indicated she was working at the facility on 2/27/26 in the morning. CNA M indicated you could smell the smoke, and she went down the hallway and assisted in looking for the fire. CNA M indicated R1 had said something about starting a fire and CNA M observed ace wrap and a burnt pile on R1's floor. CNA M indicated the pile was wet and no active flames. CNA M indicated it had been reported, and she went back to her assigned hallway and tasks. CNA M indicated as far as she knows R1 still has her smoking materials.On 3/4/26 at 1:50 PM, Receptionist N indicated she is responsible for the lock box with resident smoking materials when she is working. Receptionist N indicated the Nursing Home Administrator tells her whose smoking materials she has to keep in the lock box. Receptionist N indicated she works Monday-Friday and there is a part time front desk person as well who works on the weekends and a couple evenings a week. Receptionist N indicated that when there isn't a front desk person working, the lock box stays in the nurses' station. Receptionist N indicated she has never been told by anyone to hold R1's smoking materials or ask for it when she comes inside from smoking. Receptionist N indicated R1 has always been and continues to be able to safely handle and hold her smoking materials. Receptionist N indicated R1 has a lock box in her room where she keeps smoking materials. Receptionist N indicated she observed R1 handing her smoking materials on her own yesterday morning.On 3/4/26 at 3:40 PM, Med Tech P indicated she was not working on 2/27/26 and has not heard about R1 starting the fire. Med Tech P indicated she has received education recently on the smoking policy and oxygen.On 3/4/26 at 3:45 PM, CNA Q indicated she has received education on the smoking policy and does not usually work down R1's hallway.On 3/4/26 at 4:00 PM, RN R (Registered Nurse) indicated she is familiar with working down R1's hallway and that she is the evening supervisor for the facility. RN R indicated R1 is able to safely safeguard smoking materials and keeps items in the lock box in her room. RN R indicated she is aware of the incident with R1 starting a fire in her bedroom. RN R indicated she has observed R1 going outside to smoke holding a cigarette over the weekend. RN R indicated RN R stayed late last night to educate the 3rd shift staff on the smoking policy, procedure, and oxygen.On 3/4/26 at 2:08 PM, NHA A indicated on 2/27/26 around 10:00 AM, he was notified of the situation with R1 from staff. NHA A indicated staff told him that everything was put out. NHA A indicated he interviewed R1 immediately. NHA A indicated R1 told him that she burned a piece of string off her shoe. NHA A indicated R1 came to his office. NHA A indicated R1 gave him the lighter and then he provided education to her. NHA A (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	indicated he went over the smoking policy with R1. NHA A indicated his concern was not actual smoking, but about the smoking material. NHA A indicated R1 left the facility right after the incident and did not return until 8:30PM. NHA A indicated once she returned to the facility, she was placed on 15-minute checks. NHA A indicated he immediately started staff education and completed a sweep of all residents who smoke and have their smoking materials in their rooms. The sweep is being completed daily, and it is to ensure residents who smoke and have their materials on person are keeping items in their lock boxes in their bedrooms. NHA A indicated they did update R1's care plan to include starting the fire and care planned it as a behavior. NHA A indicated they kept R1 on 15-minute checks until she talked with psych the next day, on 2/28/26. Surveyor asked NHA A if he looked in R1's bedroom and he indicated that he did assess her room for any damage. NHA A indicated he did not see anything concerning when he went to R1's room. NHA A indicated when he interviewed R1 it seemed like she understood she didn't make a good decision and that she had let herself down. NHA A indicated that R1 understood the seriousness of the situation and that he had tried to call R1 after she left the building. NHA A indicated they did not redo the smoking assessment because it was not a concern with smoking, but rather the smoking materials. NHA A indicated he did get the knife and [NAME] from R1. R1 told NHA A that she uses these items for protection. NHA A indicated he has not seen R1 with smoking materials currently, if she has something he does not have control over if she brings items back in when she is out in the community. NHA A indicated the police were not called because R1 has not directly threatened other residents at the facility. NHA A indicated the facility is working on issuing R1 a 30-day discharge notice due to not following the smoking policy. Surveyor asked NHA A if R1 can safely have smoking materials on hand and in her lock box. NHA A indicated no, she cannot have these items. Surveyor shared with NHA A that per R1's care plan and staff interviews it appears R1 is able to have these items on person. NHA A indicated R1 is able to have smoking materials on person because the concern was R1's mental health and not if she can safely smoke. NHA A indicated R1 was on 15-minute checks until psych services met with her on 2/28/26.On 3/4/26 at 3:30 PM, NHA A indicated the facility did complete a Smoking Assessment for R1 since Surveyor recommended it. NHA A indicated they continue to do the sweep of the facility and did not find any smoking materials in R1's bedroom today. NHA A indicated they do not have control over if she brings something in from her car or community. NHA A indicated staff should be asking her for the smoking materials when she comes back. Surveyor asked NHA A who should be asking for smoking materials? NHA A indicated it depends on what time R1 returns to the facility.It is important to note that staff interviews and R1's care plan do not corroborate NHA A's statement about asking R1 for materials when she returns back to the facility.R1's Smoking and Safety Assessment completed on 3/4/26, states in part: .Does the Resident display any of the following? .10. Burned skin, clothing, furniture or other (NOT CHECKED).No concerns with being able to smoke outside building safely.It is important to note the Smoking and Safety Assessment was completed after Surveyor was asking why an assessment wasn't completed after the incident. It is also important to note it does not mention the resident started a fire in her bedroom.R1's Guardian Angel Rounds forms state in part:.3/1, 3/2, 3/3, 3/4.cigarettes secured in lockbox (if applicable) .all checked YES.(Of note: these checks do not indicate if R1 has access to a lighter or ignition material)Surveyor reviewed R1's 15-minute check documentation which was started when R1 returned to the facility on 2/27/26 and ended after she met with psych services on 2/28/26. R1's psych notes state, in part:.2/28/26 45 minute phone call with services, 2/28/26: Staff report that on 2/27/26 patient used her lighter to try to burn something off in her room, resulting in some flames. No injuries occurred. Lighter was removed from patient. Patient was placed on 15-minute safety checks. This provider talked with patient on 2/28/26. Patient was calm discussing the incident. Patient reported I tried to burn a piece of string off my shoe with my lighter. Patient reported that she was sorry for doing this and that she did not realize the dangers involved with using her lighter inside the facility. She stated, I didn't realize the risks involved with this until someone told me and now I realize the danger of using a (continued on next page)

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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	lighter with other residents on oxygen. Patient reported that my brain doesn't work right since it was cut into pieces, and I can't see things from other people's point of view. Discussed patient's mental health, and patient reported that she feels her mental health is about the same. She denied any increased mental health symptoms. She denied any suicidal or homicidal ideations. Discussed medication options, and patient did not feel that she needed to adjust her mental health medications today. Staff updated on my visit with patient.On 3/5/26 at 3:00 PM, CRN C (Corporate Registered Nurse) indicated the facility did not view the incident as unsafe smoking. CRN C indicated R1 was playing with her lighter and it was not an act of unsafe smoking. The facility was concerned for her mental health and that is why the facility acted immediately and started the 15-minute checks and reached out to psych. CRN C indicated the Smoking and Safety Assessment was completed in real time which means when they completed the assessment R1 was not demonstrating any unsafe actions and did not start a fire when they were observing her.The facility failed to reassess R1 for safety related to safe handling of smoking materials after R1 started a fire in her bedroom using her lighter that she was originally deemed safe to possess. The facility failed to identify the risk and continued to care plan and allow R1 to have smoking materials on hand even after starting a fire in her bedroom. These failures created a reasonable likelihood for serious harm to occur, thus leading to the finding of immediate jeopardy. The facility removed the jeopardy on 3/6/26. The deficient practice continues at a severity/scope level of E (potential for more than minimal harm/pattern) as the facility continues to implement the following action plan:Starting on 3/6/26 All staff re-educated on the facility's non-smoking policy prior to their next shift, including that smoking is not permitted inside the building and that smoking materials such as lighters, matches, and cigarettes must be stored at the nurse station or in an approved resident lockbox per facility policy.Starting on 3/6/26 a facility wide audit was conducted to ensure residents do not possess ignition sources or weapons. Any items identified were immediately secured according to facility policy.Starting on 3/6/26 all residents who smoke or possess smoking materials are being provided with a new smoking safety assessment. Staff were also educated that any resident demonstrating unsafe behavior with smoking materials will have materials secured and will receive an immediate reassessment, with care plan interventions implemented as appropriate such as starting fires and making threatening comments regarding weapons.On 3/6/26 residents who smoke were educated regarding not using smoking materials in the facility and safety of not starting a fire in the facility.The resident involved in the incident had smoking materials immediately secured by staff, was reassessed for safety, and care plan interventions were updated.On 3/6/26 the facility completed the following generated comprehensive list of all residents who expressed desire to smoke completed a smoking evaluation for each identified resident along with care plan revisions.The facility reviewed the smoking policy and expectations of possessions of weapons.Administrator or designee will conduct random audits 4 times weekly for 8 weeks on residents who smoke to ensure smoking is done safely, lighters/ignition materials are being kept appropriately or not in possession of those who are unsafe to have them, policy is followed, assessments are completed and care plans in place. Administrator or designee will conduct random audits 4 times weekly for 8 weeks of staff to ensure they know the proper procedures on what to do if a resident has a weapon. Administrator or designee will conduct random audits 4 times weekly for 8 weeks to ensure residents are free of weapons. Results of audits will be reviewed at QAPI for further recommendations.