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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555030	A. Building B. Wing	08/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
College Vista Post-Acute	4681 Eagle Rock Blvd. Los Angeles, CA 90041

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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48219 Based on interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) was free from involuntary seclusion (separation of a resident from other residents or from her/his room or confinement to her/his room (with or without roommates) against the resident ' s will, or the will of the resident representative), when licensed vocational nurse (LVN) 3 pushed a long table to block the facility door leading to the patio, preventing Resident 3 from going to the outdoor patio. This deficient practice restricted Resident 1 ' s movement in the facility and resulted in Resident 1 verbalizing feelings of being upset. Findings: During a review of a facility provided document titled Smoking Schedule updated 7/21/2023, indicated the facility ' s smoking scheduled times for residents who smoke listed as 9 AM, 11 AM, 1 PM, 3:30 PM, and 6:30 PM. The Smoking Schedule indicated, Smoking assessment is done upon admission for resident safety. Smoking aprons (made from a flame retardant material use for protection of smokers) are provided to residents for safety. Smoking supplies are kept by staff for safety. During a review of Resident 1 ' s care plan titled [Resident 1] is non-compliant with oxygen, dated 10/10/2023, indicated Resident 1 was using oxygen 5 liters per minute for COPD. The care plan interventions included discussing the consequences of non-compliant behavior and accepting/supporting the resident ' s decision. During a review of Resident 1 ' s Admission Record indicated Resident 1 was initially admitted on [DATE] and readmitted on [DATE], with diagnoses that included COPD exacerbation (worsening of breathing problems), acute and chronic respiratory failure (the body ' s tissues does not have enough oxygen), epilepsy (seizures), and muscle weakness. During a review of Resident 1 ' s History and Physical Examination (HPE, a comprehensive physician ' s note regarding the assessment of the resident ' s health status) signed by the attending physician (Physician 1) dated 6/6/24, indicated Resident 1 had the capacity to understand and make decisions. (continued on next page)

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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool) dated 6/12/2024, indicated the resident was moderately impaired of cognition (thought process). The MDS indicated Resident 1 required moderate/partial assistance (helper does less than half the effort) with upper body dressing, oral hygiene, sit to stand, chair transfers, and personal hygiene while Resident 1 required substantial/maximal assistance (helper does more than half the effort) for lower body dressing, toileting hygiene, putting on/taking off footwear, and sit to lying position. During a review of Resident 1 ' s care plan titled [Resident 1] is non-compliant with smoking protocols/schedule dated 12/20/2023 and revised on 6/17/2024, indicated goals that included the resident not having injuries from smoking and for the resident to inform nursing staff to remove oxygen tank prior to smoking. On 7/22/2024, an intervention was added for the resident to seek assistance and supervision from facility staff for when the resident wants to smoke. The care plan interventions included encouraging the resident to seek assistance/supervision and removing oxygen tank prior to smoking, encouraging the use of smoking apron, and respecting the resident ' s rights. During a review of Resident 1 ' s care plan titled [Resident 1] is a smoker revised on 6/18/2024, indicated goals that Resident 1 would not smoke without supervision and would not suffer injury from unsafe smoking practices. The care plan interventions included information that Resident 1 required supervision while smoking, instructing Resident 1 about facility policy on smoking, locations, times, safety concerns, notifying charge nurse immediately if it was suspected that Resident 1 has violated the facility smoking policy. During a review of Resident 1 ' s Nursing Progress Notes dated 7/20/24 at 10:42PM indicated at approximately 10:00 PM Resident 1 requested to smoke, LVN 3 explained smoking times and rules and then Resident 1 began cursing at LVN 3 for 10 minutes. The progress note did not indicate that Resident 1 ' s attending physician was notified regarding Resident 1 ' s behaviors. During a review of Resident 1 ' s Progress Notes dated 7/23/2024 timed at 4:02 PM, indicated an incident that occurred on 7/20/2024 during the night shift (11 PM to 7 AM), when Licensed Vocational Nurse (LVN 3) would not allow Resident 1 to go outside the outdoor patio to smoke. During a review of Resident 1 ' s Nursing Progress Notes dated 7/24/24 at 8:51AM indicated the Director of Nursing (DON) was conducting rounds on 7/23/24 at 12:55PM in the patio, and Resident 1 reported to the DON that Resident 1 had an issue with LVN3. The Note indicated LVN3 pushed a long table in front of the door blocking the exit (to the patio) and told Resident 1 that LVN3 was not going to allow Resident 1 to smoke outside. During a review of LVN 3 ' s written statement dated 7/25/2024 timed at 10:41 AM, indicated the incident that occurred on 7/20/2024, during the start of the night shift (11PM-7AM) when Resident 1 requested to smoke. LVN 3 informed Resident 1 that he cannot go outside because it was past the facility ' s Smoking Scheduled times and the resident got upset. The written statement indicated a table was moved from the oxygen therapy room to get a new oxygen tank for the resident. The written statement indicated the table was placed approximately one foot away from the patio entrance and would be difficult for a wheelchair to pass by. The written statement indicated Resident 1 still went out the outdoor patio smoking area while the resident ' s oxygen tank was on and attached to the resident ' s wheelchair while the resident attempted to light a cigarette. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/1/24 at 11 AM with the DON, the DON stated being informed by Resident 1 about the incident of LVN3 blocking the patio door on 7/23/24, preventing Resident 3 from entering the patio. The DON stated LVN3 told her that he intentionally blocked Resident 3 from entering the patio by using a long table. The DON stated LVN 3 blocking Resident 1 ' s movement in the facility was considered a form of seclusion causing psychosocial distress, which Resident 3 reported feeling upset. During a telephone interview on 8/1/24 at 12:04PM with Certified Nursing Assistant (CNA 2), CNA 2 stated that on 7/21/24 at around 1:00AM, Resident 1 was upset with LVN 3 and cursing at him because LVN 3 would not let him go outside into the patio. CNA 2 stated that LVN 3 had blocked the entrance to the patio using the resident ' s bedside table to prevent Resident 1 from going outside for a smoke break. During a review of the facility ' s policy and procedure titled, Abuse, Neglect and Exploitation revised 10/2022, indicated It was the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. The policy indicated to identify, correct, and intervene in situations and to assure staff assigned have knowledge of the individual residents ' care needs and behavioral symptoms. The policy indicated the facility would make efforts to ensure all residents are protected from physical and psychosocial harm.

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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** 48219 Based on observations, interviews and record reviews, the facility failed to ensure one of three sampled residents (Resident 1) was free from accident smoking hazards by failing to: 1. Supervise and monitor Resident 1, who was non-compliant with the facility's smoking policy, titled Resident Smoking, when the resident went to the facility's outdoor patio to smoke a cigarette while on oxygen. 2. Implement Resident 1's care plan interventions of being non-compliant with the facility's smoking schedule and policy that indicates facility staff would supervise Resident 1 while smoking. 3. Ensure the facility nursing staff maintained Resident 1's smoking materials, in accordance with the facility's policy and procedures (P&P) titled, Resident Smoking. 4. Revise and update Resident 1's care plan of being non-compliant with smoking schedule and smoking policies dated 6/17/2024, when Resident 1 attempted to go outside and smoke while on oxygen [a colorless, odorless, reactive gas] on 7/20/2024. 5. Designate a facility staff responsible in supervising residents while residents smoke, in accordance with the facility's policy and procedure, titled, Resident Smoking. As a result, on 7/31/2024, at around 3pm, Resident 1 went to the facility's outdoor patio and lit his cigarette while on oxygen via nasal cannula (NC- a thin, flexible tube that wraps around the head for oxygen administration). The resident sustained second degree burns (partial thickness burn that affects the first and second layer of the skin causing blistering [painful swellings that contain liquid], skin discoloration, and pain) to both cheeks, lips, singed (burned surface) facial hairs, and both hands when a flash fire ignited the oxygen flow from the resident's NC. Resident 1 was transferred to the General Acute Care Hospital (GACH) 1 via 911 emergency services on 7/31/2024. Subsequently, Resident 1 was transferred to GACH 2 Burn Center (a hospital specializing in the treatment of burns) for additional treatment. On 8/1/2024 at 5:15 PM, while onsite at the facility, the California Department of Public Health (CDPH) identified an Immediate Jeopardy situation (IJ, a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death of a resident) regarding the facility's failure to provide supervised smoking for a resident (Resident 1) who had continued non-compliance with the facility's smoking safety and policy. The survey team notified the Administrator (ADM) and the Director of Nursing (DON) of an IJ situation on 8/1/2024 at 5:15 PM, due to the facility's failure to prevent accident and provide Resident 1 with sufficient supervision during smoking while oxygen is in use. On 8/3/2024 at 11:08 AM, the Administrator (ADM) provided an acceptable IJ Removal Plan (a detailed plan to address the IJ findings). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/3/2024 at 2:08 PM, while onsite and after the surveyor verified/confirmed the facility's full implementation of the IJ Removal Plan through observation, interview, and record review, and determined the IJ situation was no longer present, the IJ was removed onsite, in the presence of the ADM and the DON. The IJ Removal Plan dated 8/3/2024, included the following: 1.Immediate action(s) taken for the resident found to have been affected include: -Complete body assessment and inventory of his personal belongings on readmission. -Interdisciplinary team (IDT) will provide education to Resident 1 on readmission regarding Resident Smoking policy, smoking information which includes the designated smoking area (across nurse's station), smoking paraphernalia (any other item designed for the consumption, use or preparation of tobacco products) will be stored by nursing in a lockbox, smoking schedule, use of ashtrays and contraindication (not recommended). -All delivery/packages will be opened by the Activity Director (AD) in front of the resident to check for smoking paraphernalia. On 8/3/2024, IDT educated and explained to resident that the package/ deliveries will be opened in his presence to ensure that there is no smoking paraphernalia for his own safety. -Daily room sweep by the assigned department manager (DM) on Monday through Friday schedule and Manager of the Day (MOD) on weekends. -Resident 1 will be on one-on-one monitoring starting 8/2/2024. When the assigned one-on-one staff is on break, a certified nurse assistant (CNA) will relieve until the staff assigned to do one-on-one returns from his/her break. 2.Identification of other residents having the potential to be affected was accomplished by: -On 8/1/2024, IDT conducted care conference with Residents 2 and 3 that are smokers. IDT discussed smoking safety, facility's smoking practices and plan of care. Copy of smoking policy and smoking information which includes the designated smoking area (across nurses' station), smoking paraphernalia will be stored by nursing in a lock box, smoking schedule, use of ashtrays and contraindication (such as oxygen use) was provided to Residents 2 and 3. -On 7/31/2024, smoking safety assessment and care plans for Residents 2 and 3 were reviewed and revised by the DON to address physical and cognitive (mental processes) factors affecting ability to smoke safely. Revisions were made to reflect all current supervision and safety interventions. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: -On 7/31/2024, staff conducted room sweep for all residents with resident's permission to ensure there is no smoking paraphernalia stored in the rooms. 37 residents were assessed as of 7/31/2024. -Smoking schedule was revised by the IDT on 8/1/2024 to reflect assigned department who will oversee smoking schedule. Activity Director (AD) and Charge Nurse will assign a specific staff to oversee smokers on a daily basis. The assignment will be posted at the nurses' station. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Starting 7/3/2024, the Director of Staff and Development (DSD) will in-service staff with the following topics. -Smoking Safety with emphasis on Handling/ Storage of Smoking paraphernalia & Inventory Delivery of Items- All Staff -Smoking Assessment - Licensed Nurses -Smoking Schedule - All staff -Smoking Care Plan Initiation & Revision - Licensed Nurses & IDT -Medical Emergency Response (Burn Management) - All Staff -Change of Condition for Resident that Smokes - All Staff -Resident that smokes and on respiratory therapy (treatments provided for the lungs such as oxygen, or medication) - all staff -Smoking policy - all staff -On 81/2024, the DSD provided Inservice to Activity Department regarding resident's package delivery. Resident will open the package in the presence of a staff member to ensure there is no smoking paraphernalia. The IDT will obtain a written or verbal consent from the resident(s) that will not comply with this will be educated by IDT regarding the Residents Smoking policy. -New hire or staff who were not able to attend the in-service will be educated prior to start of their scheduled shift. -Tentative completion of in-services will be 8/4/2024. -On 8/2/2024, IDT created a preliminary Resident Smoking policy that reflects additional safety measure for non - compliance. This preliminary policy will be presented by the IDT on the scheduled Quality Assurance (QA) meeting. The revision to the policy is stated below: -If a resident or family does not abide by the smoking policy or care plan, the plan of care may be revised to include additional safety measures identified by the IDT team to include increased supervision (visual monitoring every hour or one on one monitoring) for non - compliant residents. -The IDT will obtain a written or verbal consent from the resident prior to the resident opening the package or delivery to ensure resident's rights are not violated. Written consent will be kept in the resident medical records. -The Nursing management team will oversee assigned caregivers and residents during designated smoking times to ensure appropriate supervision and interventions are implemented and that plans of care are followed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Starting 8/1/2024, the IDT will review admission and readmission within 72 hours to verify if resident uses tobacco. The findings will be documented utilizing Admission - readmission Log. Once the resident is identified as a smoker, necessary documentation and assessment will be completed by licensed nurse. The DON or designee will audit utilizing the Resident that smokes form. -Starting 8/1/2024, Activity Department or designee will deliver packages(s) to the resident and will open the package in front of the resident to ensure that no smoking paraphernalia is inside. All package/delivery will be documented utilizing Package Delivery Log. -Starting 8/1/2024, Department Managers or designee will conduct room rounds on a Monday through Friday schedule, and Manager for the Day (MOD) on weekends. The room rounds will be conducted to check smoking paraphernalia in resident's rooms and will be documented utilizing Guardian Angel Rounds' form. If any smoking paraphernalia are found, the staff will immediately remove it and will notify Administrator for appropriate action. Findings: During a review of Resident 1's Admission Record indicated the facility initially admitted the resident on 8/27/2019 and readmitted on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD; long term inflammation of lungs that causes blockages or interference with airflow in the lungs) exacerbation(worsening of a disease), acute and chronic respiratory failure (the body's tissues does not have enough oxygen), epilepsy (seizures), and muscle weakness. During a review of a facility provided document titled Smoking Schedule updated 7/21/2023, indicated the facility's smoking scheduled times for residents who smoke listed as 9 AM, 11 AM, 1 PM, 3:30 PM, and 6:30 PM. The Smoking Schedule indicated, Smoking assessment is done upon admission for resident safety. Smoking aprons (made from a flame retardant material use for protection of smokers) are provided to residents for safety. Smoking supplies are kept by staff for safety. During a review of Resident 1's care plan titled [Resident 1] is non-compliant with oxygen, dated 10/10/2023, indicated Resident 1 was using oxygen 5 liters per minute for COPD. The care plan interventions included discussing the consequences of non-compliant behavior and accepting/supporting the resident's decision. During a review of Resident 1's Order Summary Report indicated a physician's order dated 3/13/2024, to administer oxygen via NC at 5 liters per minute, may titrate (the process of adjusting the oxygen flow) oxygen to maintain oxygen saturation (the amount of oxygen in the blood) greater or equal to 94 % (normal levels are between 95% to 100%). During a review of Resident 1's History and Physical Examination (HPE, a comprehensive physician's note regarding the assessment of the resident's health status) signed by the attending physician (Physician 1) dated 6/6/2024, indicated Resident 1 had the capacity to understand and make decisions. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of a facility record title Acknowledgement and Smoking Waiver signed by Resident 1 on 6/6/2024, indicated the resident wishes to exercise the right to smoke cigarettes while residing at the facility . The facility record indicated that in order to try to protect the lives and safety of all residents and staff, the facility requires that any resident smoking be conducted with the supervision of staff because the facility does not allow smoking unsupervised. The facility record indicated that the facility had explained to Resident 1 that the facility's designated smoking area was the Patio. During a review of Resident 1's Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool) dated 6/12/2024, indicated the resident was moderately impaired (difficulty remembering things, thinking clearly) of cognition (thought process). The MDS indicated Resident 1 required moderate/partial assistance (helper does less than half the effort) with upper body dressing, oral hygiene, sit to stand, chair transfers, and personal hygiene while Resident 1 required substantial/maximal assistance (helper does more than half the effort) for lower body dressing, toileting hygiene, putting on/taking off footwear, and sit to lying position. During a review of Resident 1's care plan titled [Resident 1] is non-compliant with smoking protocols/schedule dated 12/20/2023 and revised on 6/17/2024, indicated goals that included the resident not having injuries from smoking and for the resident to inform nursing staff to remove oxygen tank prior to smoking. On 7/22/2024, an intervention was added for the resident to seek assistance and supervision from facility staff for when the resident wants to smoke. The care plan interventions included encouraging the resident to seek assistance/supervision and removing oxygen tank prior to smoking, encouraging the use of smoking apron, and respecting the resident's rights. During a review of Resident 1's care plan titled [Resident 1] is non-compliant with smoking schedule, smoking policies, and keeping his own cigarette dated 3/6/2024 and revised on 6/17/2024, indicated goals that included for the resident to not smoke without supervision, resident would participate in decisions relating to smoking schedules and policies, and the resident would not suffer injuries from unsafe smoking practices. The care plan interventions included instructing Resident 1 about smoking risks and hazards, notifying charge nurse immediately if it is suspected the resident had violated the facility's smoking policy, observing clothing and skin for signs of cigarette burns, and instructing Resident 1 about facility policy on smoking, and locations. During a review of Resident 1's care plan titled [Resident 1] is a smoker revised on 6/18/2024, indicated goals that Resident 1 would not smoke without supervision and would not suffer injury from unsafe smoking practices. The care plan interventions included information that Resident 1 required supervision while smoking, instructing Resident 1 about facility policy on smoking, locations, times, safety concerns, notifying charge nurse immediately if it was suspected that Resident 1 has violated the facility smoking policy. During a review of facility records titled Smoking Safety - initial assessment, dated 5/9/2023, 6/5/2024, and 6/22/2024, indicated Resident 1's risk factors included impaired gait (walking) and balance. The facility records indicated the same recommendations for 5/9/2023, 6/5/2024, and 6/22/2024 Smoking Safety- V2 initial assessments, that indicated discussion of smoking cessation plan and resident smoking with staff supervision. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's care plan titled Resident is at risk for injury due to non-compliance with smoking policy creating/making his own cigarette dated 7/22/2024, indicated goals that included the resident will not cause injury to himself or to others and the resident will ask staff when he needs to smoke. The care plan interventions included to continue teaching/reminding the resident with his risk factors, frequent monitoring of resident's behavior, encourage verbalization of feelings and concerns, and for the IDT to review the resident's behavior regarding smoking needs, and informing the resident of the consequences for non-compliant behavior. During a review of Resident 1's Progress Notes dated 7/23/2024 timed at 4:02 PM, indicated an incident that occurred on 7/20/2024 during the night shift (11 PM to 7 AM), when Licensed Vocational Nurse (LVN 3) would not allow Resident 1 to go outside the outdoor patio to smoke. During a review of LVN 3's written statement dated 7/25/2024 timed at 10:41 AM, indicated the incident that occurred on 7/20/2024, during the start of the night shift (11PM-7AM) when Resident 1 requested to smoke. LVN 3 informed Resident 1 that he cannot go outside because it was past the facility's Smoking Scheduled times and the resident got upset. The written statement indicated Resident 1 still went out the outdoor patio smoking area while the resident's oxygen tank was on and attached to the resident's wheelchair while the resident attempted to light a cigarette. The written statement further indicated LVN 3 was able to remove the oxygen tank before Resident 1 was able to light the cigarette. During a review of Resident 1's record titled Change of Condition [COC] dated 7/31/2024 timed at 3 PM, indicated another incident that occurred on 7/31/2024, when Resident 1 was heard calling for help from the facility's outdoor patio. The resident was discovered to have sustained second degree burns on the resident's nose, mouth, and hands. The COC indicated Resident 1 reported having severe pain, rating it at10 out of 10 pain [numerical pain rating scale with 10 being the highest level of pain and 0 for no pain). The COC indicated that emergency services (911) where contacted, and the resident was transferred to the acute hospital (GACH 1). During a review of Resident 1's GACH 1 record titled Trauma Surgery History & Physical dated 7/31/2024 timed at 4:55 PM, indicated Resident 1 had a primary medical history of status post (medical or clinical shorthand that refers to a state after an event or intervention) explosive accident in the facility. The GACH 1 record indicated [Resident 1] was sitting in a chair, smoking cigarette with his NC oxygen, (the resident) has second degree bilateral (both) burns of the hands, singed facial hairs, second degree burns of bilateral cheeks, carbonaceous sputum (upper airway injury), with 10/10 pain. The GACH 1 record indicated Resident 1 received treatments for the burns and bilateral dressings to both hands. The GACH 1 record indicated Resident 1 would be transferred for further treatment to GACH 2 Burn Center. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's GACH 2 Burn Center records titled Inpatient Progress Note dated 7/31/2024 timed 9:50 PM, indicated the resident had deep partial thickness burns with necrotic (dead body tissues) tissues on upper and lower lips. In addition, the resident had left hand with partial thickness burn to left [NAME] (the inside) hand involving the fourth (ring finger) to the fifth digits (little finger) and right hand with partial thickness burn to right [NAME] hand at base of second digit (forefinger) to the fifth digits. Treatment plan of Santyl (ointment that removes dead infected skin) and Vashe (skin and wound cleansing solution) to hands and Bactroban (antibiotic [stops growth of bacteria] ointment) topically (applied to the skin)to the resident's face. The GACH 2 records indicated an order to give the resident Tylenol (over the counter pain medication), Gabapentin (medication for nerve pain) and oxycodone (a strong narcotic medicine used to treat severe pain) for pain as needed. During a review of Resident 1's GACH 2 Burn Center records titled Patient Discharge Instructions dated 8/2/2024 timed at 5:40 PM, indicated the resident was discharged back to the facility on [DATE] with discharge diagnoses including, second degree burns of back of the right hand, back of the left hand, head, face, and neck, and wound pain. During the facility's initial tour and observation, in the presence of the DON, on 8/1/2024 at 10:16 AM, there were warning signs observed posted at the facility's double door exit to the outdoor patio Smoking Area that indicated No oxygen is allowed beyond that point. During an interview with the DON on 8/1/2024 at 10:16 AM, the DON stated if a resident smoker was using oxygen, the facility staff would remove the resident's oxygen prior to going to the outdoor patio Smoking Area. The DON stated the warning signs had been posted on the double door exit to the outdoor patio prior to Resident 1's smoking accident on 7/31/2024. During an interview on 8/1/2024 at 10:20 AM with the DON, the DON stated the facility's process for smoking supervision was for residents who smoke to go to the Nursing Station during the Scheduled Smoking times and notify the nursing staff if they wish to smoke and then nursing staff would notify the Activity Department to supervise the residents in the outdoor smoking patio. The DON stated the facility did not have a system to monitor residents who exit the double doors to smoke in the patio outside the Smoking Schedule (9 AM, 11 AM, 1 PM, 3:30 PM, and 6:30 PM). During an interview on 8/1/2024 at 10:50 AM with the DON, the DON stated that according to her investigation, the facility staff (Nursing and Activity staff) did not know that Resident 1 went outside to smoke on 7/31/2024. The DON stated she was uncertain how Resident 1 obtained his cigarettes and lighter. The DON stated that during her investigation, she found out that Resident 1 hid the cigarettes and lighter in his room. During a concurrent interview on 8/1/2024 at 11 AM, and record review of Resident 1's Progress Notes dated 7/23/2024 timed at 4:02 PM, the Progress Notes indicated the incident that happened with Resident 1 on 7/20/2024, when LVN 3 would not allow Resident 1 to go outside the patio to smoke on 7/20/2024, during the night shift. The DON stated that on 7/20/2024, during the night shift, Resident 1 wanted to go outside, but LVN 3 blocked the outdoor patio exit to prevent Resident 1 from smoking when the resident was on oxygen. The DON stated LVN 3 did not report the incident (7/20/2023) to the DON until after a few days when Resident 1 notified her (DON) that LVN 3 blocked the outdoor patio. The DON stated LVN 3 did not complete a Change in Condition documentation or revise the resident's care plan that addressed the Resident 1 attempting to go to the patio while on oxygen. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 8/1/2024 at 12:03 PM with LVN 1, LVN 1 stated he heard Resident 1 yelling for help on 7/31/2024 at around 3 PM, which prompted him (LVN 1) to rush to the facility's outdoor patio. LVN 1 stated when he went out to the patio, he observed Resident 1 with black discoloration around the lower part of the face, nostrils, and both hands. LVN 1 stated he did not know where Resident 1 got his cigarettes and lighter or how the resident was able to go out to the facility's patio without staff supervising resident while smoking. During an interview on 8/1/2024 at 12:30 PM with LVN 2, LVN 2 stated in the afternoon of 7/31/2024, he observed Resident 1 go out to the facility's outdoor patio (Smoking Area). Shortly thereafter, LVN 2 stated he heard Resident 1 yelling for help outside the facility's outdoor patio smoking area. LVN 2 stated he went outside and removed the resident's oxygen tank. LVN 2 stated he observed black and red discoloration on Resident 1's nose, lips and both hands. LVN 2 stated he did not know how Resident 1 obtained cigarettes and lighter. Resident 1 was not allowed to keep smoking materials in his room or maintain in his possession. During an interview on 8/1/2024 at 12:46 PM with Resident 2, Resident 2 stated he was outside in the facility's outdoor smoking area patio on 7/31/2024, around 3 PM, when he observed Resident 1 removed a cigarette and a lighter from beneath his gown. Resident 2 stated when Resident 1 attempted to light the cigarette, he witnessed flames igniting and coming from the lower part of Resident 1's face. Resident 2 stated Resident 1 tried to put out the fire with his own hands. During a concurrent interview and record review of Resident 1's care plan titled [Resident 1] is non-compliant with smoking schedule, smoking policies, and keeping his own cigarette revised on 6/17/2024, on 8/1/2024 at 1 PM, Registered Nurse (RN) 1 stated the care plan indicated Resident 1 was non-compliant with smoking protocols and schedule. RN 1 stated Resident 1 was instructed to inform nursing staff to remove his oxygen tank prior to smoking in the facility's outdoor patio and seek supervision. RN 1 stated, Resident 1 was known to be non-compliant with the facility's smoking policy and keeps his cigarettes on his own. RN 1 stated that even if Resident 1's care plan indicated education was provided to Resident 1 about the Smoking Policy, the facility staff should have done more interventions, that included one-to-one supervision every shift, to ensure Resident 1's safety since he continued to be non-compliant with the smoking policy. During an interview on 8/1/2024 at 3:59 PM with Treatment Nurse [TX] 1, TX1 stated LVN 1 had called for assistance for Resident 1 on 7/31/2024 around 3 PM, TX 1 stated on 7/31/2024 upon responding to Resident 1's call for help resident 1 refused to have facial burns cleansed with saline solution (a mixture of water and salt) and requested A&D ointment (first aid salve used on burns) be applied on 7/31/2024 at the facility's outdoor smoking patio. TX 1 stated Resident 1 had a history of being non-compliant with the facility's smoking policy to seek staff supervision prior to smoking during the designated smoking times, despite being provided with education. During an interview on 8/2/2024 at 12:31 PM with the Activity Director [AD], the AD stated there had been a lack of communication between the Activity Department and Nursing Department on who is assigned to supervise the resident smokers during smoking times. The AD stated that residents are supervised during smoking by anyone who is available. The AD stated that Resident 1 sometimes hide from facility staff when he goes outside the patio to smoke. The AD stated that on 7/31/2024, during the afternoon shift [3 PM to 11 PM] she did not verbally notify the nursing staff that there was no available Activity Assistants to help supervise smoking. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 8/2/2024 at 12:45 PM, the DON stated the facility's Activity Department and overseen by the AD who had two Activity Assistants (AA) was in charge of supervising and monitoring resident smokers during smoking schedule for 9 AM, 11 AM, 1 PM, and 3:30 PM. The DON stated that the 6:30 PM smoking schedule was the last time for residents to smoke for the day. The DON stated that the Nursing Department should be assigned to supervise resident smokers at 6:30 PM. The DON stated that there was no specified facility staff from the Activity Department and Nursing Department assigned for each schedule indicated in the facility's Smoking Schedule and staffing assignments and/or the resident's care plans, as a means to communicate to all facility staff. The DON stated the staff assignments was based on verbal communication by the AD to either of the two AAs or the charge nurses to any of the nursing staff available during the morning [7 AM to 3 PM] and [3 PM to 11 PM] evening shifts. The DON stated that Nursing staff was to cover the Activity Staff (AD and AAs) in supervising resident smokers if the AD and the AAs were not available to supervise residents during the smoking schedule or outside the smoking scheduled times. During a concurrent interview and review of the facility's undated policy and procedures (P&P) titled, Resident Smoking, on 8/2/2024 at 2:18 PM, the DON stated that the P&P did not indicate what the facility's actions for residents who continued to be non-compliant with the facility's smoking policy, that included additional safety measures to protect residents who uses oxygen and who consistently do not adhere to the policy. During the same interview on 8/2/2024 at 2:18 PM, the DON stated that all resident smokers' care plans about smoking, including Resident 1 did not have the specific smoking measures designed for each resident's concerns, including communication of these safety measures to all facility staff, especially those who will be the staff responsible in supervising the residents while smoking. The DON stated that nursing staff should have added and implemented additional safety measures especially when Resident 1 was on oxygen and continued to be noncompliant of smoking safety such as removing oxygen tank before smoking. The DON stated the additional safety measure should had been a one-to-one staff supervision when the resident continued to show non-compliance to safety while smoking. The DON stated that Resident 1 had an interdisciplinary team (IDT) discussion about his care and including smoking compliance on 3/14/2024, 6/6/2024, and 7/24/2024, indicating the same information such as reeducation of facility smoking, and oxygen policies and procedures and that resident will not smoke without supervision. The DON stated Resident 1's smoking care plans were not specific to increase observation/supervision. The DON stated the facility staff should have been more attentive to Resident 1's issues and concerns and could have added a one-to one sitter, increase monitoring, remove the oxygen tank prior to resident going to the outdoor smoking area patio. The DON stated Resident 1's care plans was not specific to Resident 1's main issues and concerns. During a concurrent observation and interview on 8/3/2024 at 11:05 AM, in Resident 1's room, Resident 1 was lying in bed, with oxygen delivering 5 liters/min humidified via NC. Resident 1's bilateral hands were wrapped with gauze [a very thin, light cloth, used to cover cuts] dressing. During the observation, Resident 1 was observed with second degree burns on the lower part of the face, from the tip of the nose to both lower cheeks, down to the chin. Resident 1's lips were dark in color. Resident 1 complained of 10/10 (severe) pain. Resident 1 stated that on 7/31/2024, he lit a cigarette while on NC with oxygen flowing at 5 liters/min and the cigarette blew up in his face. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During the same interview, on 8/3/2024 at 11:05 AM, Resident 1 stated Normally, [facility] staff catches me before I go outside. Normally they see me coming before going outside, and normally they [facility staff] say wait, let me take off your oxygen. Resident 1 stated that on 7/31/2024, during that time (3 PM) the facility staff did not remind him. Resident 1 stated Resident 1 forgot that he had his oxygen on when he lit up his cigarette. Resident 1 stated when he put the cigarette in his mouth and lit it with his lighter, the cigarette exploded. Resident 1 stated that the plastic part of the NC and his face caught on fire and burnt his mustache. Resident 1 stated he tried to put the fire out by using his hands. Resident 1 stated he yelled for help and it took forever for nurses to come. Resident 1 stated he did not remember how long it took for staff to come help him. Resident 1 stated he puts his cigarettes and lighter inside his drawer in his room. Resident 1 stated he orders his smoking materials online (an activity or service available on or performed using the internet or other computer network) and stores them in his drawer. During a review of the facility's undated policy and procedures (P&P) titled, Resident Smoking, the P&P indicated the following: 1. The facility was to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. 2. Safety measures included the prohibition of oxygen use in the smoking area. 3. Smoking materials of residents requiring supervision with smoking will be maintained by nursing staff. 4. Any resident who was deemed safe to smoke, with or without supervision, will be allowed to smoke in designated smoking areas (weather permitting), at designated times, and in accordance with his/her care plan. 5. All smoking measures will be documented in each resident's care plan and communicated to all staff, visitors, and volunteers who will be responsible supervising residents while smoking. 6. If a resident or family does not abide by the smoking policy or care plan, the plan of care may be revised to include additional safety measures. During a review of the facility's policy and procedure titled Accidents and Supervision revised on 12/19/2022, indicated The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accident, to include 1. Id [TRUNCATED]

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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** 48219 Based on interview and record review, the facility failed to develop a smoking policy that identified procedures to implement and ensure the safety of one of 32 residents (Resident 1) who was noncompliant with the facility ' s smoking policy and procedure. Resident 1 who was receiving continuous oxygen therapy always kept a cigarette and lighter in his possession. On 7/31/24 Resident 1 was left unsupervised smoking in the patio when he lit up a cigarette in his mouth while an oxygen delivered via cannula (medical device to provide supplemental oxygen through the nares) tubing delivering oxygen (colorless and odorless gas needed for plant and animal life). This failure resulted in Resident 1 sustaining second degree burns (burns that affect the skin ' s top and lower layers, which may cause pain, redness, swelling, and blistering) on the lower portion of his face (from the tip of his nose, bilateral lower cheeks, around his mouth, upper lip, and lip area) and bilateral hands and was transferred to the hospital. Findings: During a review of Resident 1 ' s Admission Record (Face sheet), indicated the facility admitted the resident on 3/13/2024 and readmitted on [DATE], with diagnoses that included COPD (chronic respiratory pulmonary disease) exacerbation (worsening of breathing problems), acute (sudden) and chronic (frequent) respiratory failure (the body ' s tissues does not have enough oxygen), epilepsy (seizures), and muscle weakness. During a review of Resident 1 ' s History and Physical Examination (HPE, a comprehensive physician ' s note regarding the assessment of the resident ' s health status), signed by the attending physician (Physician 1) dated 6/6/2024, indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1 ' s Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 6/12/2024, indicated Resident 1 ' s was moderately impaired. The MDS indicated Resident 1 required moderate/partial assistance (helper doe less than half the effort) with upper body dressing, oral hygiene, site to stand, chair transfers, and personal hygiene while Resident 1 required substantial/maximal assistance (helper does more than half the effort) for lower body dressing, toileting, hygiene, putting on/taking off footwear, and sit to lying position. During a review of facility records titled Smoking Safety - V2 initial assessment, dated 5/9/2023, 6/5/2024, and 6/22/2024, indicated Resident 1 ' s risk factors included impaired gait and balance. The facility records indicated the same recommendations that indicated discussion of smoking cessation plan and resident may smoke with supervision. During a concurrent interview and record review of an undated facility titled Residents that are smokers on 8/1/2024 at 10:43AM with the Director of Nursing (DON), the DON stated there were three residents in the facility. The DON stated Resident 1, 2, and 3. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s SBAR [Situation, Background, Assessment, and Recommendations] Communication Form (communication tool to provide essential and concise information, usually during crucial situations), dated 7/31/2024, indicated Resident 1 had second degree burns on mouth, nose, and both hands due to noncompliance with smoking with O2 (Oxygen) tank. The SBAR indicated Resident 1 complained of 10 out of 10 pain, on the pain number scale (pain level scale where zero indicated no pain and 10 indicated the worst pain a person has experienced) due to the second degree burns on mouth, nose, and both hands/Face. During a concurrent interview and review of the facility ' s undated policy and procedures (P&P) titled, Resident Smoking, on 8/2/2024 at 2:18 PM, the DON stated that the P&P did not indicate what the facility ' s actions for residents who continued to be non-compliant with the facility ' s smoking policy, that included specifying increased monitoring and observation for non-compliant residents. The DON stated the facility should have included in the smoking policy the additional safety measures for residents who use oxygen to prevent accidents, injuries, and fires. During an interview on 8/2/2024 at 2:18 PM, the DON stated the additional safety measures that should have been included in the facility ' s smoking to determine if the non-compliant resident required increase supervision or involuntary discharge. The DON stated, examples of increased supervision may include a one-to-one monitoring for non-compliant smokers with oxygen therapy, removal of the oxygen tank prior to going to the smoking area, and specific staff assigned to smoke breaks. During a concurrent observation and interview on 8/3/2024 at 11:05AM with Resident 1 in Resident 1 ' s room, Resident 1 had red and black discoloration of second degree burns on his nose, mouth, bilateral lower cheeks, and lips, which were open to air. Resident 1 ' s upper lip mustache was shaved off below the nares and colored red and black. Resident 1 had the nasal tips inside his bilateral nares with the oxygen concentrator (medical device that helps deliver oxygen with individuals who have breathing problems) at 5 liter per minute (lpm, unit of measure that expresses flow rate). Resident 1 bilateral hands were wrapped in gauze and tape up to the second knuckle of his fingers. Resident 1 was able to move the tips of his fingers without difficulty. Resident 1 stated he lit a cigarette with his cannula in his nares and oxygen tank on, and it blew up in his face. Resident 1 stated the plastic part of the cannula and face caught on fire, and burnt my mustache. Resident 1 stated he tried to put out the fire with my hands. That ' s why my hands are burnt. Resident 1 stated the staff normally stops him before he goes outside to the patio. Resident 1 stated, they normally see me coming before going outside and they say ' wait [Resident 1], let me take off your oxygen ' . Resident 1 stated this time they missed it. I forgot I had my oxygen on. During a review of the facility ' s undated policy and procedures (P&P) titled, Resident Smoking, the P&P indicated the following: The facility was to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and non-smoking residents. Any resident who was deemed safe to smoke, with or without supervision, will be allowed to smoke in designated smoking areas (weather permitting), at designated times, and in accordance with his/her care plan. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	All smoking measures will be documented in each resident ' s care plan and communicated to all staff, visitors, and volunteers who will be responsible supervising residents while smoking. If a resident or family does not abide by the smoking policy or care plan, the plan of care may be revised to include additional safety measures.