STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676055	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Acres Health and Rehabilitation Center	405 Shady Acres Lane Newton, TX 75966

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs for 3 of 6 residents (Resident #s 1, 2, and 3) reviewed for comprehensive person-centered care plans. Resident #1 did not have a care plan completed after she was observed smoking a vape pen in her bathroom or after she sustained burns related to smoking while receiving oxygen therapy. Resident #2 did not have his care plan for smoking reviewed and updated when he refused to comply with the facility smoking policy. He did not sign out to smoke off facility grounds and refused to have the facility retain his smoking supplies safety. Resident #3 did not have her care plan for smoking reviewed and updated after she was found with cigarettes and lighter on 07/19/24. These failures place residents at risk for unsafe smoking. Findings included: 1. Record review of Resident #1's face sheet dated 07/23/24 indicated she was a [AGE] year-old female, admitted on [DATE], and her diagnoses included non-st elevation myocardial infarction (heart attack), anxiety (feeling of fear, dread, and uneasiness), paralytic syndrome (neuromuscular weakness that can progress to paralysis), and COPD (chronic obstructive pulmonary disease-restrictive airflow and breathing problems). Record review of Resident #1's annual MDS dated [DATE] indicated she had unclear speech, was sometimes understood, and usually understands others. She had severe impaired cognition (BIMS score of 6). Tobacco use was no. She utilized oxygen therapy. Record review of Resident #1's care plan dated 12/20/23 indicated she was on oxygen therapy related to ineffective gas exchange. Interventions included oxygen via nasal prongs at 2L continuously. There was no care plan related to tobacco use, smoking, or smoking safety. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's progress note dated 03/11/24 at 4:45 p.m., completed by LVN QQ indicated she was informed by the DON Resident #1 received a vape pen from another resident. Resident #1 was caught smoking the vape pen in her bathroom. The content of the vape pen was unknown. Resident was assessed and RP notified. Record review of the progress note dated 07/19/24 at 7:52 p.m., completed by RN ZZ indicated Resident #1 was out back (of the facility). Resident #1 was attempting to smoke a cigarette with her O2 on. During an observation and interview on 07/25/24 at 11:50 a.m., Resident #1 was sitting in her wheelchair, and had oxygen in place, connected to a concentrator. 2. Record review of Resident #2's face sheet dated 07/23/24 indicated he was a [AGE] year-old male, admitted on [DATE], and his diagnoses included cerebral infarction (stroke), chronic kidney disease, and major depressive disorder. Record review of Resident #2's quarterly MDS assessment dated [DATE] indicated he was able to make himself understood and understood others. He was cognitively intact (BIMS score 14). Record review of Resident #2's care plan dated 05/18/23 indicated Resident #2 was a smoker. Interventions included instruct resident about smoking risks and hazards and instruct resident about facility policy on smoking, locations, times, and safety concerns. Resident #2 was given a letter to show concerns about leaving the facility to smoke unsupervised. He signed the letter, and a copy was put in his clinical records. Resident #2 can sign out to leave the premises and smoke unsupervised. Notify charge nurse immediately if it was suspected Resident #2 had violated the facility smoking policy. Observe clothing and skin for signs of cigarette burns. Resident #2 required supervision while smoking. Resident #2's smoking supplies were stored at the nurses' station. Record review of Resident #2's Smoking-Safety Screen dated 05/30/23 indicated cognitive loss, dexterity problems, smokes 5-10 cigarettes per day, likes to smoke morning, afternoon, evening, and nights and needed the facility to store lighter and cigarettes. Plan of care was used to assure resident was safe while smoking. Resident #2 was safe to smoke with supervision. Resident #2 had dexterity problems following a CVA. He had cognitive impairment which could impair his safety needs with smoking. There was no Smoking-Safety Screen completed after 05/30/23. During an interview on 07/23/24 at 11:10 a.m., Resident #2 said he used to go off the facility to smoke but he now had to turn in all his smoking supplies and was only allowed to smoke with supervision. He said he never gave his cigarettes and lighter to the facility and did not sign them out to go smoking He said he kept them in his room. He said the staff never asked him for his cigarettes or lighter. 3. Record review of Resident #3's face sheet dated 07/23/24 indicated she was a [AGE] year-old female, admitted on [DATE], and her diagnoses included major depressive disorder, Parkinsonism (a broad term comprising a clinical syndrome and presenting with various neurodegenerative diseases, which manifest with motor symptoms such as rigidity, tremors, bradykinesia, and unstable posture, leading to profound gait impairment), COPD (a chronic inflammatory lung disease that causes obstructed airflow from the lungs), anxiety (feeling of fear, dread, and uneasiness), and hypertensive heart disease with heart failure. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's quarterly MDS assessment dated [DATE] indicated she was able to make herself understood and usually understood others. She was cognitively intact (BIMS score 15). Record review of Resident #3's care plan for tobacco use dated 03/21/24 indicated Resident #3 would adhere to the facility smoking policy (revised 07/09/24) and would not suffer injury from unsafe smoking practices (revised 07/09/24). Interventions included to conduct Smoking Safety Evaluation upon admission and PRN, orient resident to smoking times and procedures, and Resident #3 required supervision while smoking. Record review of Resident #3's Smoking-Safety Screen dated 03/08/24 indicated Resident #3 smoked 1-2 cigarettes per day and liked to smoke in the afternoon and evening. Resident #3 needed the facility to store lighter and cigarettes. A plan of care was used to assure Resident #3 was safe while smoking. Resident #3 was safe to smoke without supervision. Encouraged Resident #3 to sign self out of nurses' station when smoking without supervision. There was no Smoking-Safety Evaluation completed after 03/08/24. During an interview on 07/23/24 at 11:30 a.m., Resident #3 said she had smoked a cigarette. She said she gave all her smoking supplies to the nurse but could not remember which nurse. During an interview on 07/23/24 at 11:25 a.m., RN ZZ said she was not aware Resident #3 smoked. She said she thought Resident #2 was an independent smoker. She said she was not aware of a list of smokers. During an interview on 07/23/24 at 2:00 p.m. CNA YY said she was not aware of who all of the smokers were in the facility. She said the residents' cigarettes and lighters were kept at the nurses' station and taken out to the smoking area. During an interview on 07/23/24 at 2:05 p.m., CNA XX said she would get residents' cigarettes and lighters from the nurses' station and take them out to the smoking area. She said there was not a list of residents who smoked and who required supervision. She said Resident #2 and one other resident were able to smoke independently and off the facility property. She said Resident #2 kept his cigarette supplies in his room because he was an independent smoker and did not require supervision. During an interview on 07/23/24 at 2:12 p.m., LVN WW said she was not aware Resident #1 or Resident #3 smoked cigarettes. She said she was not aware of a list of residents who smoked. During an interview on 07/23/24 at 5:51 p.m., the DON said the nurses' station would have a list of residents who smoked and who required supervision or who could smoke independently. She said the nurses would advise the assigned staff of the resident supervision levels for smoking. She said Resident #2 usually kept his cigarettes and lighter. During an interview on 07/24/24 at 8:33 a.m. LVN WW said Resident #2 was an independent smoker and did not sign out smoking supplies. She said she was not aware he required supervision. She said she never asked Resident #2 for his cigarettes or lighter. She said smoking assessments were done upon admission and as needed if the residents were identified smokers. She said the smoking assessments would be done if they came up due in the electronic record. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/24/24 at 8:49 a.m., CNA YY said there was no list of smokers or who required supervision while smoking. She said Resident #2 never kept his cigarettes or lighter at the nurses' station. She said she was not aware Resident #3 was a smoker. During an interview on 07/24/24 at 8:58 a.m., QA TT said Resident #2 was supposed to sign his smoking supplies in and out when he went off facility property to smoke. She said she did not know why his supplies were not turned in or why he was not signing in and out of the facility. She said Resident #3 denied having cigarettes or smoking. She said all residents who were identified as smokers should have a smoking assessment and a care plan. She said there should be list of residents who smoked and required supervision. She said if the list was not posted at the nurses' station, it should be. She said residents were at risk of injuries due to not safely smoking if they did not have assessment or care plans and they were not supervised as required. During an interview on 07/24/24 at 9:15 a.m., the Administrator said Resident #2 was allowed to keep his cigarettes and lighter on his person because he was an independent smoker. He said Resident #2 was supposed to sign his smoking supplies in and out of the nurses' station. He said he was not aware of a list of residents who were smokers or who required supervision. During an interview on 07/24/24 at 1:23 p.m., MDS RR said resident smoking assessments were supposed to be completed quarterly. She said resident care plans were reviewed and updated quarterly and as needed. She said all smokers should have care plans related to their level of supervision. She said residents were at risk of serious injury if they were not adequately supervised when they were smoking. She said if their smoking assessments were not completed, and their care plans were not updated the staff would not be aware of their safety needs. Record review of the facility's Care Planning-Interdisciplinary Team policy dated 2001 (revised March 2022) indicated 1. Resident care plans are developed according to the timeframes and criteria established by S483. 21. 2. Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT). 3. The IDT includes but is not limited to: a. the resident's attending physician; b. a registered nurse with responsibility for the resident; c. a nursing assistant with responsibility for the resident; d. a member of the food and nutrition services staff; e. to the extent practicable, the resident and/or the resident's representative; and f. other staff as appropriate or necessary to meet the needs of the resident, or as requested by the resident. 4. The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. 5. Care plan meetings are scheduled at the best time of the day for the resident and family when possible. 6. If it is determined that participation of the resident or representative is not practicable for development of the care plan, an explanation is documented in the medical record. Record review of the facility's Smoking Policy-Residents dated 2001 (revised 2017) indicated . 2. Smoking is only permitted in designated resident smoking areas . 3. Oxygen use is prohibited in smoking areas. 6. The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. 7. The staff shall consult with the Attending physician and the Director of Nursing services to determine if the safety restriction need to be placed on a resident's smoking privileges based on the Safe Smoking Evaluation. 8. A resident's ability to smoke will be evaluated quarterly, upon significant change (physical or cognitive) and as determined by staff.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115 Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for 3 of 14 residents (Resident #s 1, 2 and 3) reviewed for smoking. 1. The facility failed to ensure Residents #2 and #3 were smoking safely in a designated smoking area. On 07/19/24, Resident #1, who utilized oxygen, and Residents #2 and #3 (assessed as smokers) were in a nonsmoking area. Resident #1's oxygen caught on fire, and she sustained multiple burns to her face, chest, and hands. 2. The facility failed to ensure Resident #2 and Resident #3 did not keep their smoking materials in their room. 3. The facility failed to ensure Residents #2 and #3 were re-assessed for smoking safety. On 07/24/24 at 12:26 p.m. an Immediate Jeopardy (IJ) situation was identified. While the IJ was removed on 07/26/24, the facility remained out of compliance at a scope of isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy, due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. These failures could place residents at risk of harm, severe injury, and possible death. Findings included: Record review of Resident #1's face sheet dated 07/23/24 indicated she was a [AGE] year-old female, admitted on [DATE], and her diagnoses included non-st elevation myocardial infarction (hear attack), anxiety (feeling of fear, dread, and uneasiness), paralytic syndrome (neuromuscular weakness that can progress to paralysis), and COPD (chronic obstructive pulmonary disease-restrictive airflow and breathing problems). Record review of Resident #1's annual MDS dated [DATE] indicated she had unclear speech, was sometimes understood, and usually understands others. She had severe impaired cognition (BIMS score of 6). Tobacco use was no. She utilized oxygen therapy. Record review of Resident #1's care plan dated 12/20/23 indicated she was on oxygen therapy related to ineffective gas exchange. Interventions included oxygen via nasal prongs at 2L continuously. There was no care plan related to tobacco use, smoking, or smoking safety. Record review of Resident #1's progress note dated 03/11/24 at 4:45 p.m., completed by LVN QQ indicated she was informed by the DON Resident #1 received a vape pen from another resident. Resident #1 was caught smoking the vape pen in her bathroom. The content of the vape pen was unknown. Resident was assessed and RP notified. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #2's face sheet dated 07/23/24 indicated he was a [AGE] year-old male, admitted on [DATE], and his diagnoses included cerebral infarction (stroke), chronic kidney disease, and major depressive disorder. Record review of Resident #2's quarterly MDS assessment dated [DATE] indicated he was able to make himself understood and understood others. He was cognitively intact (BIMS score 14). Record review of Resident #2's care plan dated 05/18/23 indicated Resident #2 was a smoker. Interventions included instruct resident about smoking risks and hazards and instruct resident about facility policy on smoking, locations, times, and safety concerns. Resident #2 was given a letter to show concerns about leaving the facility to smoke unsupervised. He signed the letter, and a copy was put in his clinical records. Resident #2 can sign out to leave the premises and smoke unsupervised. Notify charge nurse immediately if it was suspected Resident #2 has violated the facility smoking policy. Observe clothing and skin for signs of cigarette burns. Resident #2 required supervision while smoking. Resident #2's smoking supplies are stored at the nurses' station. Record review of Resident #2's Smoking-Safety Screen dated 05/30/23 indicated cognitive loss, dexterity problems, smokes 5-10 cigarettes per day, likes to smoke morning, afternoon, evening, and nights and needed the facility to stored lighter and cigarettes. Plan of care was used to assure resident was safe while smoking. Resident #2 was safe to smoke with supervision. Resident #2 had dexterity problems following a CVA. He had cognitive impairment which could impair his safety needs with smoking. There was no Smoking-Safety Screen completed after 05/30/23. Record review of Resident #3's face sheet dated 07/23/24 indicated she was a [AGE] year old female, admitted on [DATE], and her diagnoses included major depressive disorder, Parkinsonism (a broad term comprising a clinical syndrome and presenting with various neurodegenerative diseases, which manifest with motor symptoms such as rigidity, tremors, bradykinesia, and unstable posture, leading to profound gait impairment), COPD (a chronic inflammatory lung disease that causes obstructed airflow from the lungs), anxiety (feeling of fear, dread, and uneasiness), and hypertensive heart disease with heart failure. Record review of Resident #3's quarterly MDS assessment dated [DATE] indicated she was able to make herself understood and usually understood others. She was cognitively intact (BIMS score 15). Record review of Resident #3's care plan for tobacco use dated 03/21/24 indicated Resident #3 would adhere to the facility smoking policy (revised 07/09/24) and would not suffer injury from unsafe smoking practices (revised 07/09/24). Interventions included conduct Smoking Safety Evaluation upon admission and PRN, orient resident to smoking times and procedures, and Resident #3 required supervision while smoking. Record review of Resident #3's Smoking-Safety Screen dated 03/08/24 indicated Resident #3 smoked 1-2 cigarettes per day and liked to smoke in the afternoon and evening. Resident #3 needed the facility to store lighter and cigarettes. A plan of care was used to assure Resident #3 was safe while smoking. Resident #3 was safe to smoke without supervision. Encouraged Resident #3 to sign self out of nurses' station when smoking without supervision. There was no Smoking-Safety Evaluation completed after 03/08/24. (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 07/23/24 at 11:25 a.m., RN ZZ said she saw Resident #3 pushing Resident #1 toward the front door of the facility to go outside. She said then Resident #3 brought Resident #1 to the station. Resident #1 had burns to her face, hands, and chest. She said she called 911 and the physician. She said Resident #1 was sent to the hospital. She said Resident #2 did not say anything. She said Resident #3 said she was outside with Resident #1. She said Resident #1 said she wanted a cigarette. RN ZZ said Resident #3 reported Resident #2 gave Resident #1 a cigarette. She said Resident #1's oxygen tubing was split into two separate sections. She said she was not aware Resident #3 smoked. She said she thought Resident #2 was an independent smoker. She said she was not aware of a list of smokers. Record review of the progress note dated 07/19/24 at 7:52 p.m., completed by RN ZZ indicated Resident #1 was out back (of the facility). Resident #1 was attempting to smoke a cigarette with her O2 on. The O2 flashed and popped the tube in her nose. Resident #3 was the resident who assisted Resident #1 back into the building after the incident. Record review of Resident #1's Smoking Injury report dated 07/19/24 at 8:10 p.m., completed by RN ZZ indicated Resident #1 was pushed to the nurses' station by Resident #3. She had burns on her face, mouth, nose, cheeks, chin, and chest (8 inches X 6 inches). Her lips were singed, and her right hand had a 3 cm area. Resident #1 indicated It blew up. The ADON called an ambulance. The ambulance arrived and transported Resident #1 to the hospital. Record review of Resident #1's hospital records dated 07/19/24 at 9:32 p.m. indicated Resident #1 presented in respiratory distress with burns to intranasal (nose) and perioral (mouth) region with stridor (abnormal, high-pitched respiratory sound produced by irregular airflow in a narrowed airway) and wheezing (high pitched whistle when airway is blocked) . intubated (tube put into windpipe for breathing) for airway protection and expected clinical course with ketamine (anesthetic) and rocuronium (neuromuscular blocker). OG tube (orogastric) also placed. Chest x-ray revealed interstitial edema (form of pulmonary edema). Resident #1 was transferred to burn center for management evaluation. Record review of Resident #1's hospital records dated 07/20/24 indicated Resident #1 reported she had quit smoking (no date noted) and her smoking use included cigarettes. Elevated troponin myocardial injury likely due to acute myocardial injury in setting of severe burns and critical illness. There was 3% partial thickness burn to face/chest. During an interview on 07/23/24 at 11:10 a.m., Resident #2 said he was out back in the garden area of the facility with Resident #1 and Resident #3 He said it was a non-smoking area. He said he knew it was not a smoking area and he should not be smoking there. He said Resident #3 was smoking and got too close to Resident #1 and there was a flash and Resident #1 was on fire. He said he took the oxygen tube off Resident #1 and the fire went out. He denied giving Resident #1 a cigarette. He said he used to go off the facility to smoke but he now had to turn in all his smoking supplies and was only allowed to smoke with supervision. He said he did not give Resident #1 a cigarette. He said he never gave his cigarettes and lighter to the facility and did not sign them out to go smoking. He said he kept them in his room. He said the staff never asked him for his cigarettes or lighter. (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 07/23/24 at 11:30 a.m., Resident #3 said she pushed Resident #1 to the nurses' station from her room. She said LVN WW put a tank of oxygen on Resident #1's chair. She said she informed LVN WW they were going out back of the facility to look at the flowers. She said Resident #2 joined them in the back of the facility. She said she had smoked a cigarette. She said Resident #2 was also smoking. She said she got a cigarette from Resident #2 for Resident #1. She said suddenly Resident #1 exploded and was on fire. She said she did not know how the fire started. She said she did not light the cigarette for Resident #1. She said she pulled the tube from Resident #1 and the fire went out. She said she pushed Resident #1 back into the facility and to the nurses' station. She said she gave all her smoking supplies to the nurse but could not remember which nurse. She said she did not want to talk anymore of the incident and wanted a lawyer. During an interview on 07/23/24 at 9:40 a.m., the Administrator said on 07/19/24, Resident #3 wanted to take Resident #1 outside to enjoy the garden. Resident #2 joined them. Resident #2 was an independent smoker who would sign himself out and go off property to smoke. He joined Resident #1 and #3 in a nonsmoking area. Resident #2 denied giving Resident #1 a cigarette. Resident #3 denied having a cigarette or smoking. Resident #2 said it just exploded and then he said Resident #3 had a cigarette and got too close to Resident #1. There were no staff present. Resident #3 put out the fire and brought Resident #1 back into the facility. RN ZZ assessed Resident #1 with burns to her chest and face and she was sent out to the hospital and then transferred to a secondary hospital burn unit. Since the incident on 07/19/24, the facility's smoking policy changed so no residents were allowed to keep smoking materials in their room and Residents #2 and #3 now required supervision. The facility has started in-services to staff on the new policy. He said all smoking residents were educated on the new policy and signed the new policy. During an observation on 07/23/24 at 10:15 a.m. of the non-smoking area in the back of the facility indicated there was no signage to indicate it was a non-smoking area. There was no signage related to the use of oxygen. During an interview on 07/23/24 at 12:35 p.m., the DON said she was not able to locate any current Smoking-Safety assessments for Residents #1, #2, or #3. During an interview on 07/23/24 at 12:40 p.m., the Administrator said whoever admitted the resident was responsible for doing the initial Smoking-Safety Screen, then it was done as needed. He said he was not aware of who took Resident #3's cigarettes and lighter after the incident on 07/19/24. He said the area where the incident occurred was not a designated smoking area. During an interview on 07/23/24 at 2:00 p.m. CNA YY said she was not aware of who all the smokers were in the facility. She said the residents' cigarettes and lighters were kept at the nurses' station and taken out to the smoking area. She said there was not a list of residents who required supervision while smoking. She said she did not know if Resident #1 or #3 smoked. She said Resident #2 was an independent smoker and kept his cigarettes and lighter in his room. During an interview on 07/23/24 at 2:05 p.m., CNA XX said she would get residents' cigarettes and lighters from the nurses' station and take them out to the smoking area. She said there was not a list of residents who were smokers. She said Resident #2 and one other resident were able to smoke independently and off of the facility property. She said Resident #2 kept his cigarette supplies in his room because he was an independent smoker and did not require supervision. She said she did not know if Resident #1 or #3 smoked. (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 07/23/24 at 2:12 p.m., LVN WW said Resident #1 was at the nurses' station and was having trouble breathing. She said she put the oxygen tank on Resident #1's wheelchair and made sure the cannula was in place. She said Resident #3 indicated they (Resident #1 and Resident #3) were going to sit outside at the back of the facility. She said she was not aware Resident #1 or Resident #3 smoked cigarettes. She said she was not aware of a list of residents who smoked. During an interview on 07/23/24 at 5:51 p.m., the DON said the nurses' station would have a list of residents who smoked and who required supervision or who could smoke independently. She said the nurses would advise the assigned staff of the resident supervision levels for smoking. She said Resident #2 usually kept his cigarettes and lighter. She said she was responsible to make sure the quarterly Smoking-Safety Screen were completed. She said she was not aware the Smoking-Safety Screens were not completed as required. During an interview on 07/23/24 at 6:00 p.m., LVN VV said there was no list for which residents were smokers or who required supervision. She said after the incident on 07/19/24 where Resident #1 caught on fire, all the residents were supervised except one. She said all smoking supplies were supposed to be kept at the nurses' station. She said Resident #2 used to sign out and return his smoking supplies but then he refused. She said she believed the policy allowed him to keep his cigarettes and lighter because he was an independent smoker. During an interview on 07/24/24 at 8:33 a.m. LVN WW said Resident #2 was an independent smoker and did not sign out smoking supplies. She said she was not aware he required supervision. She said she never asked Resident #2 for his cigarettes or lighter. She said after the incident on 07/19/24, Resident #2 required supervision and was a supervised smoker. She said she was not aware of a list of residents who were smokers. She said the smoking supplies were handed to the staff who supervised the residents in the smoking area. She said there was one resident who was allowed to sign himself and his smoking supplies out to smoke off the facility property. She said smoking assessments were done upon admission and as needed if the residents were identified smokers. She said the smoking assessments would be done if they came up due in the electronic record. During an interview on 07/24/24 at 8:40 a.m., LVN WW said Resident #2 was an independent smoker and did not sign out smoking supplies. She said she was not aware he required supervision. She said she never asked Resident #2 for his cigarettes or lighter. She said after the incident on 07/19/24, Resident #2 required supervision and was a supervised smoker. She said she was not aware of a list of residents who were smokers. She said the smoking supplies were handed to the staff who supervised the residents in the smoking area. She said there was one resident who was allowed to sign himself and his smoking supplies out to smoke off the facility property. She said smoking assessments were done upon admission and as needed if the residents were identified smokers. She said the smoking assessments would be done if they came up due in the electronic record. During an interview on 07/24/24 at 8:49 a.m., CNA YY said all smoke breaks were assigned. She said a CNA would supervise at 4:00 p.m. She said the residents smoking supplies were given to them by the nurse. She said Resident #2 never kept his cigarettes or lighter at the nurses' station. She said he was an independent smoker before the incident on 07/19/24 but now had to smoke with supervision. She said she was not aware if Resident #1 or Resident #3 were smokers. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 07/24/24 at 8:58 a.m., QA TT said Resident #2 was supposed to sign his smoking supplies in and out when he went off the facility property to smoke. She said she did not know why his supplies were not turned in or why he was not signing in and out of the facility. She said Resident #3 denied having cigarettes or smoking. She said all residents who were identified as smokers should have a smoking assessment and a care plan. She said she was working on getting all assessments caught up and completed. She said the assessments were behind due to staff being off. She said the facility brought in a part time MDS nurse who caught up on the MDS assessments but not all other assessments. She said there should be list of residents who smoked. She said if the list of residents who smoked was not posted at the nurses' station, it should be. She said residents were at risk of injuries due to not safe smoking if they did not have assessment or care plans and they were not supervised as required. During an interview on 07/24/24 at 9:15 a.m., the Administrator stated Resident #2 was allowed to keep his cigarettes and lighter on his person because he was an independent smoker. He said the facility tried to keep Resident #2's smoking supplies and Resident #2 would promise to give them back to be kept at the nurses' station, but he would not keep his promise. He said Resident #2 was supposed to sign his smoking supplies in and out of the nurses' station. He said Resident #2 had not signed out of the facility since March 2023 due to being noncompliant and defiant. He said the facility did not have any system in place to protect the other residents from Resident #2's non-compliance or unsafe smoking. He said he would tell Resident #2 to return his smoking supplies but Resident #2 would not return his smoking supplies. He said Resident #2 knew he was not supposed to smoke on the property and smoked in a non-smoking area. He said Resident #3 denied smoking in the non-smoking area on 07/19/24. He said he was not aware of a list of residents who were smokers. He said after the incident on 07/19/24, all cigarettes and smoking paraphernalia were taken from the residents and were kept at the nurses' station. The Administrator said all smoking residents except one were to smoke during the scheduled smoking times. The Administrator said the one resident that did not require supervision could check themselves out and go off the facility premises to smoke. He said smoking was a risk and was unhealthy. During an interview on 07/24/24 at 9:43 a.m., the DON said she was not aware Resident #2 was not signing his smoking supplies in or out. She said she was not aware Resident #3 was a smoker. She said she did not know there was no list of residents who were smokers. She said she was aware the smoking assessments were not current. She said facility was working on making all smoking assessments current and up to date. She said residents were at risk of unsafe smoking if they were not supervised as required. (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 07/24/24 at 1:23 p.m., MDS RR said Resident #2 reported Resident #3 pushed Resident #1 outside to the back garden area. She said the area was a nonsmoking area. She said Resident #2 reported Resident #3 had a lit cigarette and bent down in front of Resident #1 and there was a flash and fire. She said Resident #3 reported it was a freak accident and did not know what happened. MDS RR said resident smoking assessments were supposed to be completed quarterly. She said resident care plans were reviewed and updated quarterly and as needed. She said all smokers should have care plans related to their level of supervision. She said she did not know why the smoking assessments were not current. She said the smoking assessments were not activated in the electronic record and the nurses would not know to do the assessments if they did not populate. She said she had to activate Residents #1, #2, and #3's smoking assessments. She said residents were at risk of serious injury if they were not adequately supervised when they were smoking. She said if their smoking assessments were not completed, and their care plans were not updated the staff would not be aware of their safety needs. During an interview on 07/25/24 at 11:20 a.m., QA TT said Residents #1, #2, and #3 had gone outside to smoke. They did not go to the designated smoking area, but went to the garden area, way in the back. Resident #1 was on oxygen. A spark ignited and Resident #1 got burned. She was sent to the hospital and then transferred to a secondary hospital burn unit. She said none of the residents would say what exactly happened, and it was unknown if Resident #1 had a cigarette or not. Resident #1 had her oxygen tubing on at the time, but it was not hooked up to her concentrator. The Resident returned to the facility on [DATE]. She sustained 2nd and 3rd degree burns to her face and chest. Resident #1 was initially intubated for the edema and received ketamine and Fentanyl (opioid used for pain relief). QA TT said Resident #1 had a hard time communicating. She had a communication board but did not use it. She said all smoke breaks were now supervised and residents were required to sign out. During an observation and interview on 07/25/24 at 11:50 a.m., Resident #1 was sitting in her wheelchair, and had oxygen in place, connected to a concentrator. Resident #1 was noted with contractures to both hands. Resident #1 had a hard time speaking but was able to answer questions. She stated she was outside on 07/19/24 sitting with Resident #2 and Resident #3. She was not in the usual smoking area. She heard a boom and then her shirt caught fire. She was sitting next to Resident #3 who was smoking at the time. Resident #2 was also smoking. She said Resident #2 and Resident #3 put the fire out and she went to the hospital. She did not remember too much after being admitted to the hospital. Resident #1 said she had her oxygen tubing on at the time of the incident, but it was not hooked up to her concentrator. Resident #1 said she smoked a long time ago but was not a smoker and did not have a cigarette at the time of the incident. Resident #1 said she had gone outside with both residents before, but she usually kept her tubing across her lap. She said the cannula was in her nose. She would go outside with them 1-2 times a week. Resident #1 said she had burns above her mouth, directly under her nose, and to her chest. Red areas were noted to Resident #1's upper lip area and under her nose. A dressing was in place to the right upper chest area. QA TT raised the bottom of the dressing where the tape had come loose. Wounds appeared to black in color with some blood noted. Resident #1 said it was very painful and QA TT said she would bring her something for pain. (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 observation and interview on 07/25/24 at 12:30 p.m., Resident #2 was sitting in his wheelchair. He had lived in the facility for 1 year. He said on 07/19/24 he went outside to smoke with Residents #1 and #3. They did not go to the designated smoking area, and instead went to the garden area as there was better scenery. Resident #3 was sitting in a chair and lit a cigarette. The minute she started to smoke it he saw a flash of fire. He immediately took Resident #1's oxygen tubing off as it had melted to her face. He said Resident #1's shirt was also on fire. He said he had a Dr. Pepper and a towel he had brought outside. He poured the drink on her shirt and used the towel to put the fire out. He said Resident #1 was crying and in shock. Resident #1 had also burned her hand and nose. He said Resident #3 brought Resident #1 inside the facility. Resident #2 said he now had to smoke at the designated times. Resident #2 said he got a letter from the Administrator stating he had to move out. He said the Administrator said he had given Resident #1 a cigarette. Resident #2 said he did not give her a cigarette, and he was not even smoking at the time. He said Resident #3 was the only one smoking at the time. He said the Administrator just assumed he gave her one. He had never seen Resident #1 smoke since he had been in the facility. He said she must have done it before because she had COPD. Resident #2 said Resident #1 was his girlfriend. Resident #2 said 2-3 months ago he had a vape pen with THC (Tetrahydrocannabinol-a cannabinoid found in cannabis) in it and Resident #1 took a hit. He said the Administrator told him to not do it again. Record review of the facility's Smoking Policy-Residents dated 2001 (revised 2017) indicated . 2. Smoking is only permitted in designated resident smoking areas . 3. Oxygen use is prohibited in smoking areas. 6. The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. 7. The staff shall consult with the Attending physician and the Director of Nursing services to determine if the safety restriction need to be placed on a resident's smoking privileges based on the Safe Smoking Evaluation. 8. A resident's ability to smoke will be evaluated quarterly, upon significant change (physical or cognitive) and as determined by staff. This was determined to be an Immediate Jeopardy (IJ) on 07/24/24. The Administrator and DON were notified. The Administrator was provided with the IJ template on 07/24/24 at 12:26 p.m. The following plan of removal was submitted by the facility and accepted on 07/26/24 at 9:59 a.m. and included the following: On 22 July 2024 the Administrator implemented a smoking policy which states no resident shall be allowed to smoke on (the facility's) property unsupervised. Residents are to follow posted smoking schedule. This smoking schedule also reflects which staff is responsible for which times. Staff in-service training on this new policy was completed on 25 July 2024 at 6 p.m. Assessment of all residents who smoke or who we think may be sneaking a smoke was completed by QA nurse on 25 July 2024 12:00 noon. Residents were also assessed for the possible need of protective equipment. QA nurse has also updated all resident's care plans to reflect the results of the assessment (completed 26 July 12 noon). QA nurse will ensure quarterly assessments are completed in a timely manner. A list of residents who smoke, along with those that need protective equipment, was posted on top of the smoking box that is carried out to smoking area by supervising staff (24 July 2024). All staff were instructed to read the smoking list that is taped to the lid of the smoking box and put a smoking apron on residents as indicated by said list. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administration has reiterated to residents, who often leave facility grounds, the policy that they must sign out before leaving and sign back in upon return. All residents who have been identified as smokers have signed acknowledgement of their understanding of this policy on 23 July 2024 at 12 noon. Smoking questionnaire, as of 24 July 2024 12 noon, is now a part of admission package to determine if the resident may be a smoker. Care plan team has updated resident #2's care plan to reflect he is no longer allowed to keep smoking material on his person or in his room. Resident #2 has been instructed to sign himself out when he leaves the building and sign himself in upon his return. Resident #1 and #3 have been assessed as smokers. Residents #1 and #3's care plans have been updated to reflect the fact that they may try to sneak around and smoke. On 24 July 2024 administration implemented a policy that all smoking on the facility property will be supervised. All staff has been instructed on smoking safety and supervision (completed 25 July 2024 at 6 p. m. by DON and Admin) to ensure that hazardous materials are kept away from the designated smoking area. All staff has been instructed by the DON and the Administrator to request the return of smoking material that any resident checks out upon resident's return to facility (completed 25 July 2024 at 6 p.m.). All staff has been instructed by the DON on smoking safety and supervision (completed 25 July 2024 at 6 p.m.) to ensure that hazardous materials are kept away from designated smoking area. New policy compliance will be monitored by the Administrator, the DON, the QA Nurse as well as the weekly QA Rounds team. On 07/26/24 the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: During observations of a facility smoking area on 07/26/24 at 4:00 p.m. and 7:00 p.m., there was one staff with residents. Two residents had on a smoking apron. Staff lit residents' cigarettes with lighter. No residents retained smoking paraphernalia. There was a box with residents' smoking materials. There was a list of resident smokers taped to top of the box of residents' smoking materials that included who required safety interventions (protective apron). During an interview on 07/26/24 at 3:45 p.m., the DON said staff were in-serviced on the facility's smoking policy. She said shifts have changed recently to 6a-6p and 6p-6a for nurses and CNAs. She said residents who smoked were instructed on the revised Smoking Policy. During an interview on 07/26/24 at 4:10 p.m., QA TT said in-services were conducted with staff and residents. She said Smoking Assessments were updated on smokers and done on residents suspected of smoking. She said she reviewed and updated the care plans based on the Smoking Assessment. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interviews conducted on 07/26/24 from 4:45 p.m. through 6:15 p.m. with the facility staff from all shifts (CNA A, CNA B, CNA C, NA D, DA E, DA F, RN G, CNA H, LVN I, CNA J, CNA K, and Maintenance Director L) indicated they were aware of the facility smoking policy, knew which residents required smoking protection (aprons), were aware residents were required to turn in smoking paraphernalia, and would report any resident to the charge nurse if they were non-compliant with return of smoking paraphernalia. They were able to explain the importance of assessing each resident for smoking safety, ensuring all residents adhered to the smoking policy and smoking contracts, and knew the consequences of non-compliance, ensuring residents do not keep their own smoking materials or smoke unsupervised, ensuring the families of residents who smoked complied with all smoking rules, posting all designated smoking hours to ensure each resident was available during those times, ensuring residents on oxygen or those with roommates on oxygen did not keep lighters in their rooms, and reporting any non-compliance with the smoking policy to management. They were of where the list of smokers was (on the box of resident smoking materials). During an interview on 07/26/24 at 6:20 p.m., Resident #2 said he was aware of the new smoking policy, smoking schedule, supervision, wearing a protective apron, and signing out to smoke off the premises. He said cigarettes and lighters we [TRUNCATED]

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F 0926 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115 Based on observation, interview, and record review, the facility failed to follow Federal, State, and Local laws and regulations regarding smoking, smoking areas, and smoking safety for 3 of 3 residents (Resident #s 1, 2, and 3) reviewed for smoking safety. 1. The facility failed to ensure Residents #2 and #3 were smoking safely in a designated smoking area. On 07/19/24, Resident #1, who utilized oxygen, and Residents #2 and #3 (assessed as smokers) were in a nonsmoking area. Resident #1's oxygen caught on fire, and she sustained multiple burns to her face, chest, and hands. 2. The facility failed to ensure Residents #2 and Resident #3 were supervised while they were smoking. 3. The facility failed to ensure Resident #2 and Resident #3 did not keep their smoking materials in their room. 4. The facility failed to ensure Resident #2 and #3 were re-assessed for smoking safety. On 07/24/24 at 12:26 p.m. an Immediate Jeopardy (IJ) situation was identified. While the IJ was removed on 07/26/24, the facility remained out of compliance at a scope of isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy, due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. These failures could place residents at risk of an unsafe smoking environment and an increased risk of injury related to smoking. Findings included: Record review of Resident #1's face sheet dated 07/23/24 indicated she was a [AGE] year-old female, admitted on [DATE], and her diagnoses included non-st elevation myocardial infarction (hear attack), anxiety (feeling of fear, dread, and uneasiness), paralytic syndrome (neuromuscular weakness that can progress to paralysis), and COPD (chronic obstructive pulmonary disease-restrictive airflow and breathing problems). Record review of Resident #1's annual MDS dated [DATE] indicated she had unclear speech, was sometimes understood, and usually understands others. She had severe impaired cognition (BIMS score of 6). Tobacco use was no. She utilized oxygen therapy. Record review of Resident #1's care plan dated 12/20/23 indicated she was on oxygen therapy related to ineffective gas exchange. Interventions included oxygen via nasal prongs at 2L continuously. There was no care plan related to tobacco use, smoking, or smoking safety. (continued on next page)

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F 0926 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's progress note dated 03/11/24 at 4:45 p.m., completed by LVN QQ indicated she was informed by the DON Resident #1 received a vape pen from another resident. Resident #1 was caught smoking the vape pen in her bathroom. The content of the vape pen was unknown. Resident was assessed and RP notified. Record review of Resident #2's face sheet dated 07/23/24 indicated he was a [AGE] year-old male, admitted on [DATE], and his diagnoses included cerebral infarction (stroke), chronic kidney disease, and major depressive disorder. Record review of Resident #2's quarterly MDS assessment dated [DATE] indicated he was able to make himself understood and understood others. He was cognitively intact (BIMS score 14). Record review of Resident #2's care plan dated 05/18/23 indicated Resident #2 was a smoker. Interventions included instruct resident about smoking risks and hazards and instruct resident about facility policy on smoking, locations, times, and safety concerns. Resident #2 was given a letter to show concerns about leaving the facility to smoke unsupervised. He signed the letter, and a copy was put in his clinical records. Resident #2 can sign out to leave the premises and smoke unsupervised. Notify charge nurse immediately if it was suspected Resident #2 has violated the facility smoking policy. Observe clothing and skin for signs of cigarette burns. Resident #2 required supervision while smoking. Resident #2's smoking supplies are stored at the nurses' station. Record review of Resident #2's Smoking-Safety Screen dated 05/30/23 indicated cognitive loss, dexterity problems, smokes 5-10 cigarettes per day, likes to smoke morning, afternoon, evening, and nights and needed the facility to stored lighter and cigarettes. Plan of care was used to assure resident was safe while smoking. Resident #2 was safe to smoke with supervision. Resident #2 had dexterity problems following a CVA. He had cognitive impairment which could impair his safety needs with smoking. There was no Smoking-Safety Screen completed after 05/30/23. Record review of Resident #3's face sheet dated 07/23/24 indicated she was a [AGE] year old female, admitted on [DATE], and her diagnoses included major depressive disorder, Parkinsonism (a broad term comprising a clinical syndrome and presenting with various neurodegenerative diseases, which manifest with motor symptoms such as rigidity, tremors, bradykinesia, and unstable posture, leading to profound gait impairment), COPD (a chronic inflammatory lung disease that causes obstructed airflow from the lungs), anxiety (feeling of fear, dread, and uneasiness), and hypertensive heart disease with heart failure. Record review of Resident #3's quarterly MDS assessment dated [DATE] indicated she was able to make herself understood and usually understood others. She was cognitively intact (BIMS score 15). Record review of Resident #3's care plan for tobacco use dated 03/21/24 indicated Resident #3 would adhere to the facility smoking policy (revised 07/09/24) and would not suffer injury from unsafe smoking practices (revised 07/09/24). Interventions included conduct Smoking Safety Evaluation upon admission and PRN, orient resident to smoking times and procedures, and Resident #3 required supervision while smoking. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0926 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #3's Smoking-Safety Screen dated 03/08/24 indicated Resident #3 smoked 1-2 cigarettes per day and liked to smoke in the afternoon and evening. Resident #3 needed the facility to store lighter and cigarettes. A plan of care was used to assure Resident #3 was safe while smoking. Resident #3 was safe to smoke without supervision. Encouraged Resident #3 to sign self out of nurses' station when smoking without supervision. There was no Smoking-Safety Evaluation completed after 03/08/24. During an interview on 07/23/24 at 11:25 a.m., RN ZZ said she saw Resident #3 pushing Resident #1 toward the front door of the facility to go outside. She said then Resident #3 brought Resident #1 to the station. Resident #1 had burns to her face, hands, and chest. She said she called 911 and the physician. She said Resident #1 was sent to the hospital. She said Resident #2 did not say anything. She said Resident #3 said she was outside with Resident #1. She said Resident #1 said she wanted a cigarette. RN ZZ said Resident #3 reported Resident #2 gave Resident #1 a cigarette. She said Resident #1's oxygen tubing was split into two separate sections. She said she was not aware Resident #3 smoked. She said she thought Resident #2 was an independent smoker. She said she was not aware of a list of smokers. Record review of the progress note dated 07/19/24 at 7:52 p.m., completed by RN ZZ indicated Resident #1 was out back (of the facility). Resident #1 was attempting to smoke a cigarette with her O2 on. The O2 flashed and popped the tube in her nose. Resident #3 was the resident who assisted Resident #1 back into the building after the incident. Record review of Resident #1's Smoking Injury report dated 07/19/24 at 8:10 p.m., completed by RN ZZ indicated Resident #1 was pushed to the nurses' station by Resident #3. She had burns on her face, mouth, nose, cheeks, chin, and chest (8 inches X 6 inches). Her lips were singed, and her right hand had a 3 cm area. Resident #1 indicated It blew up. The ADON called an ambulance. The ambulance arrived and transported Resident #1 to the hospital. Record review of Resident #1's hospital records dated 07/19/24 at 9:32 p.m. indicated Resident #1 presented in respiratory distress with burns to intranasal (nose) and perioral (mouth) region with stridor (abnormal, high-pitched respiratory sound produced by irregular airflow in a narrowed airway) and wheezing (high pitched whistle when airway is blocked) . intubated (tube put into windpipe for breathing) for airway protection and expected clinical course with ketamine (anesthetic) and rocuronium (neuromuscular blocker). OG tube (orogastric) also placed. Chest x-ray revealed interstitial edema (form of pulmonary edema). Resident #1 was transferred to burn center for management evaluation. Record review of Resident #1's hospital records dated 07/20/24 indicated Resident #1 reported she had quit smoking (no date noted) and her smoking use included cigarettes. Elevated troponin myocardial injury likely due to acute myocardial injury in setting of severe burns and critical illness. There was 3% partial thickness burn to face/chest. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Acres Health and Rehabilitation Center	405 Shady Acres Lane Newton, TX 75966

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0926 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 07/23/24 at 11:10 a.m., Resident #2 said he was out back in the garden area of the facility with Resident #1 and Resident #3 He said it was a non-smoking area. He said he knew it was not a smoking area and he should not be smoking there. He said Resident #3 was smoking and got too close to Resident #1 and there was a flash and Resident #1 was on fire. He said he took the oxygen tube off Resident #1 and the fire went out. He denied giving Resident #1 a cigarette. He said he used to go off the facility to smoke but he now had to turn in all his smoking supplies and was only allowed to smoke with supervision. He said he did not give Resident #1 a cigarette. He said he never gave his cigarettes and lighter to the facility and did not sign them out to go smoking. He said he kept them in his room. He said the staff never asked him for his cigarettes or lighter. During an interview on 07/23/24 at 11:30 a.m., Resident #3 said she pushed Resident #1 to the nurses' station from her room. She said LVN WW put a tank of oxygen on Resident #1's chair. She said she informed LVN WW they were going out back of the facility to look at the flowers. She said Resident #2 joined them in the back of the facility. She said she had smoked a cigarette. She said Resident #2 was also smoking. She said she got a cigarette from Resident #2 for Resident #1. She said suddenly Resident #1 exploded and was on fire. She said she did not know how the fire started. She said she did not light the cigarette for Resident #1. She said she pulled the tube from Resident #1 and the fire went out. She said she pushed Resident #1 back into the facility and to the nurses' station. She said she gave all her smoking supplies to the nurse but could not remember which nurse. She said she did not want to talk anymore of the incident and wanted a lawyer. During an interview on 07/23/24 at 9:40 a.m., the Administrator said on 07/19/24, Resident #3 wanted to take Resident #1 outside to enjoy the garden. Resident #2 joined them. Resident #2 was an independent smoker who would sign himself out and go off property to smoke. He joined Resident #1 and #3 in a nonsmoking area. Resident #2 denied giving Resident #1 a cigarette. Resident #3 denied having a cigarette or smoking. Resident #2 said it just exploded and then he said Resident #3 had a cigarette and got too close to Resident #1. There were no staff present. Resident #3 put out the fire and brought Resident #1 back into the facility. RN ZZ assessed Resident #1 with burns to her chest and face and she was sent out to the hospital and then transferred to a secondary hospital burn unit. Since the incident on 07/19/24, the facility's smoking policy changed so no residents were allowed to keep smoking materials in their room and Residents #2 and #3 now required supervision. The facility has started in-services to staff on the new policy. He said all smoking residents were educated on the new policy and signed the new policy. During an observation on 07/23/24 at 10:15 a.m. of the non-smoking area in the back of the facility indicated there was no signage to indicate it was a non-smoking area. There was no signage related to the use of oxygen. During an interview on 07/23/24 at 12:35 p.m., the DON said she was not able to locate any current Smoking-Safety assessments for Residents #1, #2, or #3. During an interview on 07/23/24 at 12:40 p.m., the Administrator said whoever admitted the resident was responsible for doing the initial Smoking-Safety Screen, then it was done as needed. He said he was not aware of who took Resident #3's cigarettes and lighter after the incident on 07/19/24. He said the area where the incident occurred was not a designated smoking area. (continued on next page)

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F 0926 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 07/23/24 at 2:00 p.m. CNA YY said she was not aware of who all the smokers were in the facility. She said the residents' cigarettes and lighters were kept at the nurses' station and taken out to the smoking area. She said there was not a list of residents who required supervision while smoking. She said she did not know if Resident #1 or #3 smoked. She said Resident #2 was an independent smoker and kept his cigarettes and lighter in his room. During an interview on 07/23/24 at 2:05 p.m., CNA XX said she would get residents' cigarettes and lighters from the nurses' station and take them out to the smoking area. She said there was not a list of residents who were smokers. She said Resident #2 and one other resident were able to smoke independently and off of the facility property. She said Resident #2 kept his cigarette supplies in his room because he was an independent smoker and did not require supervision. She said she did not know if Resident #1 or #3 smoked. During an interview on 07/23/24 at 2:12 p.m., LVN WW said Resident #1 was at the nurses' station and was having trouble breathing. She said she put the oxygen tank on Resident #1's wheelchair and made sure the cannula was in place. She said Resident #3 indicated they (Resident #1 and Resident #3) were going to sit outside at the back of the facility. She said she was not aware Resident #1 or Resident #3 smoked cigarettes. She said she was not aware of a list of residents who smoked. During an interview on 07/23/24 at 5:51 p.m., the DON said the nurses' station would have a list of residents who smoked and who required supervision or who could smoke independently. She said the nurses would advise the assigned staff of the resident supervision levels for smoking. She said Resident #2 usually kept his cigarettes and lighter. She said she was responsible to make sure the quarterly Smoking-Safety Screen were completed. She said she was not aware the Smoking-Safety Screens were not completed as required. During an interview on 07/23/24 at 6:00 p.m., LVN VV said there was no list for which residents were smokers or who required supervision. She said after the incident on 07/19/24 where Resident #1 caught on fire, all the residents were supervised except one. She said all smoking supplies were supposed to be kept at the nurses' station. She said Resident #2 used to sign out and return his smoking supplies but then he refused. She said she believed the policy allowed him to keep his cigarettes and lighter because he was an independent smoker. During an interview on 07/24/24 at 8:33 a.m. LVN WW said Resident #2 was an independent smoker and did not sign out smoking supplies. She said she was not aware he required supervision. She said she never asked Resident #2 for his cigarettes or lighter. She said after the incident on 07/19/24, Resident #2 required supervision and was a supervised smoker. She said she was not aware of a list of residents who were smokers. She said the smoking supplies were handed to the staff who supervised the residents in the smoking area. She said there was one resident who was allowed to sign himself and his smoking supplies out to smoke off the facility property. She said smoking assessments were done upon admission and as needed if the residents were identified smokers. She said the smoking assessments would be done if they came up due in the electronic record. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0926 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 07/24/24 at 8:40 a.m., LVN WW said Resident #2 was an independent smoker and did not sign out smoking supplies. She said she was not aware he required supervision. She said she never asked Resident #2 for his cigarettes or lighter. She said after the incident on 07/19/24, Resident #2 required supervision and was a supervised smoker. She said she was not aware of a list of residents who were smokers. She said the smoking supplies were handed to the staff who supervised the residents in the smoking area. She said there was one resident who was allowed to sign himself and his smoking supplies out to smoke off the facility property. She said smoking assessments were done upon admission and as needed if the residents were identified smokers. She said the smoking assessments would be done if they came up due in the electronic record. During an interview on 07/24/24 at 8:49 a.m., CNA YY said all smoke breaks were assigned. She said a CNA would supervise at 4:00 p.m. She said the residents smoking supplies were given to them by the nurse. She said Resident #2 never kept his cigarettes or lighter at the nurses' station. She said he was an independent smoker before the incident on 07/19/24 but now had to smoke with supervision. She said she was not aware if Resident #1 or Resident #3 were smokers. During an interview on 07/24/24 at 8:58 a.m., QA TT said Resident #2 was supposed to sign his smoking supplies in and out when he went off the facility property to smoke. She said she did not know why his supplies were not turned in or why he was not signing in and out of the facility. She said Resident #3 denied having cigarettes or smoking. She said all residents who were identified as smokers should have a smoking assessment and a care plan. She said she was working on getting all assessments caught up and completed. She said the assessments were behind due to staff being off. She said the facility brought in a part time MDS nurse who caught up on the MDS assessments but not all other assessments. She said there should be list of residents who smoked. She said if the list of residents who smoked was not posted at the nurses' station, it should be. She said residents were at risk of injuries due to not safe smoking if they did not have assessment or care plans and they were not supervised as required. During an interview on 07/24/24 at 9:15 a.m., the Administrator stated Resident #2 was allowed to keep his cigarettes and lighter on his person because he was an independent smoker. He said the facility tried to keep Resident #2's smoking supplies and Resident #2 would promise to give them back to be kept at the nurses' station, but he would not keep his promise. He said Resident #2 was supposed to sign his smoking supplies in and out of the nurses' station. He said Resident #2 had not signed out of the facility since March 2023 due to being noncompliant and defiant. He said the facility did not have any system in place to protect the other residents from Resident #2's non-compliance or unsafe smoking. He said he would tell Resident #2 to return his smoking supplies but Resident #2 would not return his smoking supplies. He said Resident #2 knew he was not supposed to smoke on the property and smoked in a non-smoking area. He said Resident #3 denied smoking in the non-smoking area on 07/19/24. He said he was not aware of a list of residents who were smokers. He said after the incident on 07/19/24, all cigarettes and smoking paraphernalia were taken from the residents and were kept at the nurses' station. The Administrator said all smoking residents except one were to smoke during the scheduled smoking times. The Administrator said the one resident that did not require supervision could check themselves out and go off the facility premises to smoke. He said smoking was a risk and was unhealthy. (continued on next page)

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F 0926 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 07/24/24 at 9:43 a.m., the DON said she was not aware Resident #2 was not signing his smoking supplies in or out. She said she was not aware Resident #3 was a smoker. She said she did not know there was no list of residents who were smokers. She said she was aware the smoking assessments were not current. She said facility was working on making all smoking assessments current and up to date. She said residents were at risk of unsafe smoking if they were not supervised as required. During an interview on 07/24/24 at 1:23 p.m., MDS RR said Resident #2 reported Resident #3 pushed Resident #1 outside to the back garden area. She said the area was a nonsmoking area. She said Resident #2 reported Resident #3 had a lit cigarette and bent down in front of Resident #1 and there was a flash and fire. She said Resident #3 reported it was a freak accident and did not know what happened. MDS RR said resident smoking assessments were supposed to be completed quarterly. She said resident care plans were reviewed and updated quarterly and as needed. She said all smokers should have care plans related to their level of supervision. She said she did not know why the smoking assessments were not current. She said the smoking assessments were not activated in the electronic record and the nurses would not know to do the assessments if they did not populate. She said she had to activate Residents #1, #2, and #3's smoking assessments. She said residents were at risk of serious injury if they were not adequately supervised when they were smoking. She said if their smoking assessments were not completed, and their care plans were not updated the staff would not be aware of their safety needs. During an interview on 07/25/24 at 11:20 a.m., QA TT said Residents #1, #2, and #3 had gone outside to smoke. They did not go to the designated smoking area, but went to the garden area, way in the back. Resident #1 was on oxygen. A spark ignited and Resident #1 got burned. She was sent to the hospital and then transferred to a secondary hospital burn unit. She said none of the residents would say what exactly happened, and it was unknown if Resident #1 had a cigarette or not. Resident #1 had her oxygen tubing on at the time, but it was not hooked up to her concentrator. The Resident returned to the facility on [DATE]. She sustained 2nd and 3rd degree burns to her face and chest. Resident #1 was initially intubated for the edema and received ketamine and Fentanyl (opioid used for pain relief). QA TT said Resident #1 had a hard time communicating. She had a communication board but did not use it. She said all smoke breaks were now supervised and residents were required to sign out. During an observation and interview on 07/25/24 at 11:50 a.m., Resident #1 was sitting in her wheelchair, and had oxygen in place, connected to a concentrator. Resident #1 was noted with contractures to both hands. Resident #1 had a hard time speaking but was able to answer questions. She stated she was outside on 07/19/24 sitting with Resident #2 and Resident #3. She was not in the usual smoking area. She heard a boom and then her shirt caught fire. She was sitting next to Resident #3 who was smoking at the time. Resident #2 was also smoking. She said Resident #2 and Resident #3 put the fire out and she went to the hospital. She did not remember too much after being admitted to the hospital. Resident #1 said she had her oxygen tubing on at the time of the incident, but it was not hooked up to her concentrator. Resident #1 said she smoked a long time ago but was not a smoker and did not have a cigarette at the time of the incident. Resident #1 said she had gone outside with both residents before, but she usually kept her tubing across her lap. She said the cannula was in her nose. She would go outside with them 1-2 times a week. Resident #1 said she had burns above her mouth, directly under her nose, and to her chest. Red areas were noted to Resident #1's upper lip area and under her nose. A dressing was in place to the right upper chest area. QA TT raised the bottom of the dressing where the tape had come loose. Wounds appeared to black in color with some blood noted. Resident #1 said it was very painful and QA TT said she would bring her something for pain. (continued on next page)

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F 0926 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation and interview on 07/25/24 at 12:30 p.m., Resident #2 was sitting in his wheelchair. He had lived in the facility for 1 year. He said on 07/19/24 he went outside to smoke with Residents #1 and #3. They did not go to the designated smoking area, and instead went to the garden area as there was better scenery. Resident #3 was sitting in a chair and lit a cigarette. The minute she started to smoke it he saw a flash of fire. He immediately took Resident #1's oxygen tubing off as it had melted to her face. He said Resident #1's shirt was also on fire. He said he had a Dr. Pepper and a towel he had brought outside. He poured the drink on her shirt and used the towel to put the fire out. He said Resident #1 was crying and in shock. Resident #1 had also burned her hand and nose. He said Resident #3 brought Resident #1 inside the facility. Resident #2 said he now had to smoke at the designated times. Resident #2 said he got a letter from the Administrator stating he had to move out. He said the Administrator said he had given Resident #1 a cigarette. Resident #2 said he did not give her a cigarette, and he was not even smoking at the time. He said Resident #3 was the only one smoking at the time. He said the Administrator just assumed he gave her one. He had never seen Resident #1 smoke since he had been in the facility. He said she must have done it before because she had COPD. Resident #2 said Resident #1 was his girlfriend. Resident #2 said 2-3 months ago he had a vape pen with THC (Tetrahydrocannabinol-a cannabinoid found in cannabis) in it and Resident #1 took a hit. He said the Administrator told him to not do it again. Record review of the facility's Smoking Policy-Residents dated 2001 (revised 2017) indicated . 2. Smoking is only permitted in designated resident smoking areas . 3. Oxygen use is prohibited in smoking areas. 6. The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. 7. The staff shall consult with the Attending physician and the Director of Nursing services to determine if the safety restriction need to be placed on a resident's smoking privileges based on the Safe Smoking Evaluation. 8. A resident's ability to smoke will be evaluated quarterly, upon significant change (physical or cognitive) and as determined by staff. This was determined to be an Immediate Jeopardy (IJ) on 07/24/24. The Administrator and DON were notified. The Administrator was provided with the IJ template on 07/24/24 at 12:26 p.m. The following plan of removal was submitted by the facility and accepted on 07/26/24 at 9:59 a.m. and included the following: On 22 July 2024 the Administrator implemented a smoking policy which states no resident shall be allowed to smoke on (the facility's) property unsupervised. Residents are to follow posted smoking schedule. This smoking schedule also reflects which staff is responsible for which times. Staff in-service training on this new policy was completed on 25 July 2024 at 6 p.m. Assessment of all residents who smoke or who we think may be sneaking a smoke was completed by QA nurse on 25 July 2024 12:00 noon. Residents were also assessed for the possible need of protective equipment. QA nurse has also updated all resident's care plans to reflect the results of the assessment (completed 26 July 12 noon). QA nurse will ensure quarterly assessments are completed in a timely manner. A list of residents who smoke, along with those that need protective equipment, was posted on top of the smoking box that is carried out to smoking area by supervising staff (24 July 2024). All staff were instructed to read the smoking list that is taped to the lid of the smoking box and put a smoking apron on residents as indicated by said list. (continued on next page)

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F 0926 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administration has reiterated to residents, who often leave facility grounds, the policy that they must sign out before leaving and sign back in upon return. All residents who have been identified as smokers have signed acknowledgement of their understanding of this policy on 23 July 2024 at 12 noon. Smoking questionnaire, as of 24 July 2024 12 noon, is now a part of admission package to determine if the resident may be a smoker. Care plan team has updated resident #2's care plan to reflect he is no longer allowed to keep smoking material on his person or in his room. Resident #2 has been instructed to sign himself out when he leaves the building and sign himself in upon his return. Resident #1 and #3 have been assessed as smokers. Residents #1 and #3's care plans have been updated to reflect the fact that they may try to sneak around and smoke. On 24 July 2024 administration implemented a policy that all smoking on the facility property will be supervised. All staff has been instructed on smoking safety and supervision (completed 25 July 2024 at 6 p. m. by DON and Admin) to ensure that hazardous materials are kept away from the designated smoking area. All staff has been instructed by the DON and the Administrator to request the return of smoking material that any resident checks out upon resident's return to facility (completed 25 July 2024 at 6 p.m.). All staff has been instructed by the DON on smoking safety and supervision (completed 25 July 2024 at 6 p.m.) to ensure that hazardous materials are kept away from designated smoking area. New policy compliance will be monitored by the Administrator, the DON, the QA Nurse as well as the weekly QA Rounds team. On 07/26/24 the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: During observations of a facility smoking area on 07/26/24 at 4:00 p.m. and 7:00 p.m., there was one staff with residents. Two residents had on a smoking apron. Staff lit residents' cigarettes with lighter. No residents retained smoking paraphernalia. There was a box with residents' smoking materials. There was a list of resident smokers taped to top of the box of residents' smoking materials that included who required safety interventions (protective apron). During an interview on 07/26/24 at 3:45 p.m., the DON said staff were in-serviced on the facility's smoking policy. She said shifts have changed recently to 6a-6p and 6p-6a for nurses and CNAs. She said residents who smoked were instructed on the revised Smoking Policy. During an interview on 07/26/24 at 4:10 p.m., QA TT said in-services were conducted with staff and residents. She said Smoking Assessments were updated on smokers and done on residents suspected of smoking. She said she reviewed and updated the care plans based on the Smoking Assessment. (continued on next page)

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F 0926 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interviews conducted on 07/26/24 from 4:45 p.m. through 6:15 p.m. with the facility staff from all shifts (CNA A, CNA B, CNA C, NA D, DA E, DA F, RN G, CNA H, LVN I, CNA J, CNA K, and Maintenance Director L) indicated they were aware of the facility smoking policy, knew which residents required smoking protection (aprons), were aware residents were required to turn in smoking paraphernalia, and would report any resident to the charge nurse if they were non-compliant with return of smoking paraphernalia. They were able to explain the importance of assessing each resident for smoking safety, ensuring all residents adhered to the smoking policy and smoking contracts, and knew the consequences of non-compliance, ensuring residents do not keep their own smoking materials or smoke unsupervised, ensuring the families of residents who smoked complied with all smoking rules, posting all designated smoking hours to ensure each resident was available during those times, ensuring residents on oxygen or those with roommates on oxygen did not keep lighters in their rooms, and reporting any non-compliance with the smoking policy to management. They were of where the list of smokers was (on the box of resident smoking materials). During an interview on 07/26/24 at 6:20 p.m., Resident #2 said he wa [TRUNCATED]