DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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RECEIVED
AUG 24 2011
Division of Health Care
Southern Enforcement Branch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185337		07/22/2011

NAME OF PROVIDER OR SUPPLIER
LEE COUNTY CARE & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
249 EAST MAIN STREET
BEATTYVILLE, KY 41311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS --AMENDED A standard health survey and extended survey was conducted on 07/19-22/11. An abbreviated standard survey (KY16730) was also conducted at this time. The allegation was substantiated with deficient practice identified. Immediate Jeopardy was identified on 07/20/11, and was determined to exist on 07/15/11. On 07/15/11, Resident #1 was smoking while wearing nasal oxygen in the facility's designated smoking area. The oxygen ignited, catching the resident's face and beard on fire. Resident #1 was transferred to the local hospital for treatment and evaluation, and then transferred to a trauma center on 07/15/11, for evaluation of burns by the Plastic Surgery service. The resident was discharged back to the facility on 07/18/11, with diagnoses of first and second degree burns to the face, eyelids, nose, cheeks, and lips, and blisters on both hands. The facility was notified of the Immediate Jeopardy on 07/20/11. Deficiencies were cited at 42 CFR 483.25 Quality of Care (F323), 42 CFR 483.75 Administration (F490), and 42 CFR 483.75 Administration (F518) at a scope and severity of "J." Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care (F323). An acceptable Allegation of Compliance was received on 07/22/11, which alleged removal of Immediate Jeopardy on 07/19/11. An extended survey was conducted on 07/22/11, and the State Agency determined the Immediate Jeopardy was	F 000	Lee County Care and Rehabilitation Center does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X5) DATE: 08/18/11

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.

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F 000	Continued From page 1 removed on 07/19/11, prior to exit, which lowered the scope and severity to "D" at 42 CFR 483.25 (F323), 42 CFR 483.75 (490), and 42 CFR 483.75 (F518) while the facility monitors the effectiveness of systemic changes and quality assurance activities.	F 000	F 253 Address what corrective action will be accomplished for those residents found to be affected by the deficient practice/Specific corrective action.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253	No residents were identified. 1. The Housekeeping/Laundry Supervisor removed the bedside commodes in resident rooms C-10 and C-20 and replaced with new ones on 7/22/11.	
	This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain maintenance and housekeeping services necessary to maintain a sanitary, comfortable, and orderly environment. Observation revealed bedside commodes were discolored with rough legs and seats; floor tiles were cracked and stained; bedside tables and doors had splintered edges; a baseboard was loose, and a privacy curtain was stained. The findings include: During the environmental tour with the Maintenance Director conducted on 07/22/11, at 10:45 AM, the following areas were observed to be in need of maintenance/housekeeping services. 1. Residents' bedside commodes on the C Hall		2. The Maintenance Staff replaced the cracked and stained tile in resident rooms C-9 and C-20 on 08/16/10. The Maintenance Staff will replace or repair the cracked and stained tile in the C-Wing shower room. 3. The Maintenance Staff removed the bedside table with ragged and rough edges in resident room C-9 and replaced with another bedside table on 8/16/11. The Maintenance Staff installed a handle on the bedside table with the missing handle in resident room C-18 on 7/25/11. 4. The Maintenance Staff repaired resident room C-16 entrance door with splintered edges on 7/22/11.	

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F 253	Continued From page 2 in resident rooms C-10 and C-20 were observed to have rust color and roughness on the legs and seat support bars. 2. Resident rooms C-9 and C-20 and the resident shower room on the C Hall had floor tiles that were cracked and stained. 3. The bedside tables in resident rooms C-9 and C-18 were observed to be ragged and rough around the edges and/or had missing handles. 4. Resident room C-16 had an entrance door with splintered edges. 5. The bathroom in resident room A-8 had a baseboard loose and broken away from the wall. 6. Resident room B-15 had a stained privacy curtain. An interview with the Maintenance Supervisor (MS) conducted on 07/22/11, at 10:45 AM, revealed the MS was responsible for the repair and maintenance of the facility. The MS stated he monitored the entire facility weekly for needed repairs. In addition the MS revealed a maintenance request form was located at the nurses' station. When any staff member identifies a problem with maintenance issues a request was filled out and forwarded to the Maintenance Department for repairs. The MS had not received requests for repair of the above identified areas and was unaware of the identified needed repairs. An interview with the Housekeeper Supervisor on 07/22/11, at 3:40 PM, revealed she was	F 253	5. The Maintenance Staff repaired the loose baseboard in resident room A-8 on 7/25/11. 6. The Housekeeping Staff removed and cleaned the stained privacy curtain on 7/22/11. <u>Address how the facility will identify other residents having the potential to be affected by the same deficient practice/Explanation of steps taken to identify other areas of same deficient practice.</u> 1. The Housekeeping/Laundry Director checked all resident rooms for bedside commodes for rust and roughness on the legs and seat support bars on 8/11/11. 2. The Maintenance Director and Housekeeping /Laundry Supervisor checked all resident rooms and shower rooms for cracked and stained tiles on 8/12/11. 3. The Maintenance Director and the Housekeeping/Laundry Supervisor checked all resident rooms for bedside tables with ragged and rough edges and/or missing handles on 8/12/11.	

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F 253	Continued From page 3 responsible for the cleanliness of the facility. In addition the HS revealed dirty privacy curtains were usually identified and reported by the staff. If the resident's privacy curtain was soiled Housekeeping removed and cleaned the privacy curtain.	F 253	4. The Maintenance Director checked all resident room entrance doors for splintered edges on 8/12/11. 5. The Maintenance Director checked all resident rooms for loose and broken baseboards on 8/12/11.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide services in accordance with professional standards for one of twenty-six sampled residents. Resident #14 had a physician's order for heel boots which were not applied. The findings include: Review of Resident #14's medical record revealed the resident was re-admitted to the facility on 02/07/11, with diagnoses that included Dehydration, Osteoarthritis, Chronic Pain, Anemia, Lumbar Disk Discectomy, and Hip Replacement. Review of the Admission Minimum Data Set (MDS) Assessment, dated 03/14/11, revealed the facility assessed the resident to have impairment in cognitive skills, required extensive to total assistance with most Activities of Daily Living (ADL), and was at risk for developing pressure ulcers. The Care Area Assessment (CAA)	F 281	6. The Housekeeping/Laundry Supervisor checked all resident rooms for stained privacy curtains on 7/22/11. <u>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</u> 1. The Housekeeping/Laundry Supervisor and/or Maintenance Director will complete environmental rounds on one unit per week to check for housekeeping and maintenance issues. 2. The Housekeeping/Laundry Supervisor and Maintenance Director in-serviced housekeeping, laundry, and maintenance staff on checking rooms for bedside commodes needing to be replaced, areas with cracked or stained tiles, bedside tables needing repaired, splintered doors, loose	

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F 281	Continued From page 4 Summary identified Resident #14 as being at risk for altered skin integrity including skin tears, injury, and breakdown related to decreased physical function and severe cognitive impairment. Review of Resident #14's Treatment Administration Record, dated July 2011, stated, "Heel lift boots when in bed," and was ordered on 03/25/11. Record review of Resident #14's Comprehensive Plan of Care, dated 07/06/11, revealed the listed intervention, "heel lift boots when in bed" for the identified problem, "red area on right ankle." Observation of the resident on 07/20/11, at 9:00 AM and 3:40 PM, revealed the resident in bed without heel lift boots in use. Interview on 07/20/11, at 3:25 PM, with the State Registered Nurse Aide (SRNA) assigned to assist Resident #14 with care revealed she was unaware the resident was to have heel boots on since she did not see any at the resident's bedside. Interview with the Unit Coordinator on 07/20/11, at 4:00 PM, revealed the resident was to have heel lift boots but could not locate them in the resident's room or laundry. Interview on 07/20/11, at 6:38 PM, with Licensed Practical Nurse (LPN) #2, Resident #14's assigned nurse, revealed she was not aware that the resident needed to have the heel lift boots on while in bed.	F 281	F 253 baseboards, and dirty or stained privacy curtains. Staff were instructed to address any housekeeping issue or complete maintenance orders for any maintenance issue. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained. 1. The Housekeeping/Laundry Supervisor and/or Maintenance Director will complete environmental rounds on one unit per week to check for housekeeping and maintenance issues. Rounds will be on-going. 2. The Administrator will validate the environmental rounds once per month to ensure completion and findings. Validation will be on-going. Any issues identified will be addressed immediately, and results of the rounds reported to the monthly QA committee, with system revisions, staff training, and/or disciplinary actions, as needed. Include dates when corrective actio will be completed.	
F 323	483.25(h) FREE OF ACCIDENT	F 323		08/31/11

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F 323 SS=J	Continued From page 5 HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, investigation review, record review, and policy review, it was determined the facility failed to have an effective system to ensure adequate supervision was provided to prevent avoidable accidents. The facility failed to adequately supervise one of twenty-six sampled residents (Resident #1) that had been assessed to require staff supervision while smoking. On 07/15/11, Resident #1 was smoking while wearing nasal oxygen in the facility's designated smoking area. After the resident had smoked almost the entire cigarette, the oxygen ignited, catching the resident's face and beard on fire. Resident #1 was transferred to the local hospital for treatment and evaluation, and then transferred to a trauma center on 07/15/11, for evaluation of burns by the Plastic Surgery service. The resident was discharged back to the facility on 07/18/11, with diagnoses of first and second degree burns to the face, eyelids, nose, cheeks, and lips, and blisters on both hands. The facility's failure to ensure residents received	F 323	F281 Address what corrective action will be accomplished for those residents found to be affected by the deficient practice. Resident #14: The heel protectors/lift boots were placed on the resident's foot as per physician orders on 07/20/11. The SRNA and the Nurse were educated on 7-20-11 by the Unit Coordinator to read the C.N.A. care record, the comprehensive care plan or the physician orders to ensure all orders are being followed. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. 1. The Director of Nursing and Medical Records Director audited residents' charts to identify residents with physician orders for specialty devices, including heel protectors/lift boots. 2. Residents identified with physician orders for specialty devices, including heel protectors/lift boots, were checked	

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F 323	Continued From page 6 supervision to prevent accidents placed residents in the facility at risk for serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 07/20/11, and was determined to exist on 07/15/11. The facility was notified on 07/20/11. An acceptable Allegation of Compliance was received on 07/22/11, which alleged removal of Immediate Jeopardy on 07/19/11. The State Agency determined the Immediate Jeopardy was removed on 07/19/11, prior to exit, which lowered the scope and severity to "D" at 42 CFR 483.25 (F323) while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: A review of the facility's policy titled "Contraband Discovery-Smoking" (dated December 2010) revealed all residents who smoke were to be supervised by designated facility staff. The policy revealed all smoking materials such as lighters, matches, and cigarettes, were required to be kept in the nurses' medication room. The policy further stated the facility would be responsible for lighting resident smoking material. The policy revealed smoking would not be permitted in any areas with oxygen related devices. A review of the medical record for Resident #1 revealed the resident had been admitted to the facility on 06/20/11, with diagnoses to include Chronic Obstructive Pulmonary Disease (COPD) and Chronic Respiratory Failure. A review of the smoking assessment completed on 06/20/11, revealed the facility assessed Resident #1 to	F 323	F 281 for proper placement and positioning. No other residents were noted to be affected. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. 1. Any change in scope/plan of treatment will be documented on the 24 hour shift report. Interdisciplinary team will check 24 hour shift report during daily clinical meeting. The Unit Managers/Staff Development Coordinator will follow-up to ensure orders are written and followed as ordered. A list of all residents that have orders for specialty devices was developed by the Director of Nursing and is maintained in front of the TAR and C.N.A. care record for reference. The list is brought to clinical meeting and is updated as physician orders are read, by the Director of Nursing or Unit Managers. 2. The Unit Manager/Staff Development Coordinator will complete daily room rounds to confirm physician orders are followed and	

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F 323	Continued From page 7 require supervision by the facility staff while smoking. The smoking evaluation further revealed Resident #1 required staff assistance with lighting tobacco products. A review of the facility's Incident/Occurrence Investigation, dated 07/20/11, at 7:15 PM, revealed Resident #1 was smoking in the smoke room with his/her oxygen tank on the back of the wheelchair when the oxygen ignited and caught Resident #1 on fire. The Investigation revealed Resident #1's face and hands were "charred black" and the resident's facial hair was singed. The Investigation further revealed the resident's physician was notified and the resident was transferred by ambulance to the local hospital. A review of the facility's Investigation Report completed on 07/20/11, revealed on 07/15/11, at 7:15 PM, Nursing Assistant (NA) #1 was assigned to monitor the resident's smoke break. According to the Investigation Report, Resident #1 entered the facility's designated smoking area in his/her electric wheelchair with an oxygen canister, which was turned on, attached to the back of the wheelchair and a nasal cannula in his/her nose. The Investigation Report further revealed NA #1 had not observed the nasal cannula and gave Resident #1 a cigarette and proceeded to light the cigarette. The report revealed three residents (Residents #9, #24, and #25) were in the smoke room when Resident #1 entered the room. However, two of the residents (Residents #9 and #24) finished smoking and exited the smoke room, leaving Residents #1 and #25 and NA #1 in the resident smoke room. The report revealed NA #1 saw smoke and observed Resident #1's facial hair smoking, and	F 323	F 281 specialty devices are in use. 3. The Director of Nursing will in-service the professional nursing staff on noting changes in scope/plan of treatment on the 24 hour shift report each day, the nursing staff on following physician orders, and the Unit Managers/Staff Development Coordinator on completing daily room rounds to confirm physician orders are followed and use of specialty devices per physician orders. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained. 1. The Director of Nursing will review the daily room rounds weekly to ensure the rounds are completed and that any issues identified have been followed up on immediately. 2. The Director of Nursing will audit 10% of residents' charts each week to ensure physician orders are being followed and will validate placement and use of specialty devices.	

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F 323	Continued From page 8 then an immediate flash of flame. NA #1 yelled for help and ran out of the room. When staff arrived to the smoke room Resident #1 had put out the fire on his/her face with his/her hands. The Investigation Report revealed upon returning to the smoke room staff observed Resident #1 attempting to put out the fire on the oxygen tubing by using his/her hands. A review of the local hospital Emergency Room report revealed Resident #1 was transferred to the local hospital for treatment and evaluation, and then transferred to a trauma center on 07/15/11, for evaluation of burns by the Plastic Surgery service. The resident was discharged back to the facility on 07/18/11, with diagnoses of first and second degree burns to the face, eyelids, nose, cheeks, and lips. In addition, the resident also sustained blisters to both hands. An observation of Resident #1 on 07/19/11, at 1:10 PM, revealed the resident had burns on the face and blisters on both hands. The resident's upper forehead was observed to be red. The resident was complaining of pain related to the burns and was receiving Percocet 10/325 four times per day. An interview conducted on 07/19/11, at 1:45 PM, with Resident #1 revealed he/she forgot to turn off the oxygen prior to entering the resident smoke room. The resident further stated, "I always take my oxygen into the smoke room with me. I always turn it off when I go into the room. No facility staff has ever told me I couldn't take the oxygen tank into the smoke room." An interview conducted with NA #1 on 07/19/11,	F 323	F 281 3. Any issues will be addressed immediately with findings reported to the QA Committee monthly, with revisions, staff training, and/or disciplinary actions, as needed. Include dates when corrective action will be completed: F 323 Address what corrective action will be accomplished for those residents found to be affected by the deficient practice/specific corrective action. 1. On 7-15-11 resident #1 oxygen tank was turned off by Nurse Kim Henson, RN and the resident was immediately removed from the smoke room and taken to the A/B nurses station where cold compresses were applied. Notification to MD, Family and Hospital was made by Tina Byrd, RN and Chasidy Johnson, RN, with new orders received. The resident's physical condition was assessed. The resident was talking, alert and oriented and remained calm. The oxygen saturation was noted to be at 81%. Oxygen was applied. MD order was obtained and resident was transported	08/31/11

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F 323	Continued From page 9 at 2:25 PM, revealed Resident #1 always came into the smoke room with oxygen, but would turn it off prior to entering. The NA revealed she was the only staff person monitoring the designated resident smoke room on 07/15/11. The NA revealed Residents #9, #24, and #25 were already in the smoke room when Resident #1 entered. The NA gave Resident #1 a cigarette and lit the cigarette and Residents #9 and #24 left the room. The NA further revealed she was talking to Resident #25 and noticed Resident #1 was relighting his/her cigarette. Per interview she was unsure where the resident had obtained the lighter, and stated it was not the same lighter she had used to initially light the cigarette. NA #1 stated after Resident #1 had smoked almost the entire cigarette, she heard a sizzling noise, and the oxygen ignited, catching the resident's face and beard on fire. The NA stated she immediately left the smoke room screaming and ran to the AB nurses' station to notify a nurse. The interview further revealed when the NA returned to the smoke room, Resident #1 had put out the fire on his/her face with his/her hands, and was trying to put out the fire to the nasal cannula on the floor with his/her hands. The NA stated she was so scared at that time she just didn't know what to do. An interview with the Director of Nursing (DON) on 07/20/11, at 3:00 PM, revealed any staff member could be assigned to monitor the smoke room except the Therapy staff. The DON revealed the Contraband Discovery Smoking policy was reviewed in orientation. The DON further stated NA #1 should never have allowed Resident #1 to enter the smoke room with the oxygen tank and the oxygen tank should have	F 323	F 323 per EMS to Marcum Wallace Hospital. MD and Family were aware. Resident #25 was transported in her wheelchair by Rebecca Stewart, NA, out of the smoke room upon identification of concern of resident #1. The resident was alert and oriented with no apparent injuries or obvious signs or symptoms of respiratory or physical distress. Further assessment of resident #25 by Scarlett Caudill, RN, revealed that the resident's respiratory status was stable and vital signs were within normal limits with no signs of distress. The family and MD were notified on 7-15-11 by Scarlett Caudill, RN, with no new orders received. 2. A thorough investigation was initiated on 7-15-11 by Nurse Kim Henson with further direction from Administrator, Director of Nursing and Social Services Director to determine if any other residents were affected. None were identified. Rebecca Stewart, N.A. was suspended pending investigation on 7-15-11. 3. Kim Henson, RN, initiated staff education on 7-15-11 at approximately 7:45 pm on the smoking policy,	

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F 323	Continued From page 10	F 323	F 323	

been left outside the door. The DON revealed upon seeing Resident #1 using a lighter NA #1 should have confiscated the lighter and taken it to the nurses' station and reported the resident's behavior to the nurse. The DON also stated NA #1 should have used the fire blanket to extinguish the fire on the face of Resident #1. The DON stated the NA should have called for help from the door and should not have left the residents in the room alone.

Further interview with NA #1 on 07/19/11, at 2:25 PM, revealed she had not received any training on monitoring residents in the smoke room. The NA stated she had not been trained by the facility prior to the incident on how to use the fire blanket and she did not know what to do when Resident #1 caught on fire.

An interview with the facility's Administrator on 07/20/11, at 4:15 PM, revealed the Administrator had been notified of the incident on 07/15/11. The Administrator stated Resident #1 came into the resident smoke room with an oxygen tank. The Administrator revealed the NA panicked and should have used the fire blanket to extinguish the fire and yell for help from the door.

**An acceptable Allegation of Compliance (AOC) was received on 07/22/11, which alleged removal of Immediate Jeopardy on 07/19/11. An extended survey was conducted on 07/22/11, which determined the Immediate Jeopardy was removed on 07/19/11. A review of the Allegation of Compliance revealed the following:

- NA #1 was terminated on 07/20/11, for allowing Resident #1 to enter the resident smoke room including oxygen is not allowed in the smoke room, for the facility staff that were present in the building at the time of the incident.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

All residents have the potential to be affected regarding accidents as numerous and various accident hazards exist in everyday life. The facility staff understands the facility's responsibility as well as their own, to ensure the safest environment possible for residents.

1. Smoking assessments were completed on the all residents by Rachel Steele, LPN, Della Creech, RN and Tresa Bowman, RN, on 7-15-11. Care plans were updated and revised by Rachel Steele, LPN, Della Creech, RN, if needed per smoking assessment.

2. Stephanie Robinson RT reviewed all residents on 7-15-11 requiring oxygen administration and noted compliance of room signage noting oxygen in use

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F 323	Continued From page 11 with oxygen. - Residents #1 and #25 were interviewed on 07/18/11, by the Social Services Director (SSD) and Administrator in attempt to identify any psychosocial concerns related to the smoking incident on 07/15/11. According to the AOC, psychosocial interviews would continue for seven days, or longer if necessary, by the SSD. - Smoking assessments were completed on all residents on 07/15/11, and resident care plans were updated/revised as needed. - On 07/16/11, all residents in the facility who smoked were reassessed for a smoking apron or oxygen usage. A list of residents who smoked was updated and kept in the smoking box to alert staff to each resident's specific safety needs. - On 07/15/11, all residents' rooms that required oxygen had signage noting oxygen was in use and in compliance with oxygen administration. In addition, the facility posted a sign on the smoke room door that stated oxygen was not permitted in the smoke room. - All active staff persons were educated prior to their next working shift regarding the facility's smoking policy and what to do in an emergency situation. The education began on 07/15/11. - Letters were sent to all families and hand delivered to residents on 07/16/11, to remind the families and residents of the facility's smoking policies and procedures. Effective 07/17/11, a copy of the smoking and contraband policies would be given to all newly admitted residents	F 323	and compliance with oxygen administration. 3. On 7-15-11, the Social Service Director and Director of Nursing performed room search for contraband with the residents' permission of all residents. No contraband was found. 4. A letter regarding the smoking policy was mailed to the families and hand delivered to the facility's resident by the Administrator on 7-16-11. The letter includes the following safety rules; smoking areas only, all residents who smoke will be supervised by designated facility staff, all smoking materials (lighters, matches, cigarettes, etc.) are to be kept by facility staff for distribution and smoking in NOT permitted in any area with oxygen related devices. 5. The Director of Nursing in-serviced the staff on the response to an emergency situations with a fire and with supervision of residents that smoke. The in-service included; Rescue, Alarm, Contain, Evacuate, return demonstration of a resident with and without oxygen, when observed to have the presence of	

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F 323	Continued From page 12 and families. - On 07/15/11, at 10:30 PM, an auditing tool was developed to ensure safety in the smoking lounge. An additional staff person was required to monitor the staff person who was assigned to monitor the resident smoke break. **The Allegation of Compliance was verified by the following: - A review of the Social Services notes on 07/22/11, for Residents #1 and #25, dated 07/15/11 through 07/21/11, revealed the residents were interviewed by the Social Services Director and the Administrator to identify any psychosocial concerns related to the incident. Resident #1 had been hospitalized on 07/15/11. The psychosocial interviews began again for Resident #1 upon the resident's return to the facility on 07/18/11. - On 07/22/11, a review of a list found in the smoking box located at the A/B nurses' station revealed the list had been updated on 07/16/11, to include the resident's assessed needs while smoking. - A tour of the facility on 07/22/11, at 4:15 PM, revealed Residents #1, #29, and #35 required oxygen therapy, and had signs posted on the room doors to alert anyone entering that oxygen was in use and no smoking was allowed. The tour also revealed a large sign posted on the resident smoke room alerting anyone entering that oxygen was not permitted in the room. - A review of the medical records for Residents	F 323	smoke/ fire, of monitoring the smoke break, including reviewing the list of resident specific interventions located in each smoke box and ensuring oxygen equipment does not enter the smoke room. <u>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</u> 1. All active staff will be educated by Staff Development, DON, ADONs, MDS coordinators, Administrator and/or nursing supervisors on accidents to include that the resident environment remains as free of accident hazards as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents. 2. The Interdisciplinary team which will include Administrator, Director of Nursing or a member of nursing administration, and plant operations, has reviewed the orientation process and procedure for new employees and the annual orientation. The IDT discussed and reviewed the disaster/fire safety plan to develop a	

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F 323	Continued From page 13 #27, #28, #29, #30, #31, #32, #33, #34, and #35 revealed smoking assessments were completed on all residents with care plans being updated and revised as necessary by LPN #1 and RN #6 on 07/15/11. - A review of the education rosters revealed all active staff in the facility had been educated prior to working regarding the facility's smoking policy and oxygen policy, with a return demonstration of interventions for emergency events related to smoking and fire. The roster revealed the education began on 07/15/11. Interviews on 07/22/11, between 1:30 PM and 4:00 PM, with State Registered Nursing Assistants (SRNAs) #6, #12, and #13, Housekeeper #13, Licensed Practical Nurse #3, and RN #2 revealed all staff was aware of the smoking policy, oxygen policy, and safety interventions. In addition, staff was knowledgeable regarding the list kept in the smoking box. - A review of the letter mailed to families and hand delivered to residents in the facility on 07/16/11, revealed smoking was to be allowed in designated smoke areas only, would not be permitted in any area with oxygen related devices, and residents who smoked would be monitored by facility staff. The letter further revealed facility staff was required to keep all smoking materials. - A review of an admission packet for new residents revealed the facility's policy titled "Contraband Discovery-Smoking" had been added to be given to all new residents and families.	F 323	plan for demonstration and post testing. The Interdisciplinary team will develop an annual in-service training schedule for emergency preparedness and response. 3. The smoke break auditing tool was initiated to ensure oxygen is not in the smoke room, a fire extinguisher, smoke blanket and extra smoking aprons are in the smoke room, that residents have all safety interventions in place as assessed, and that motorized wheelchairs are not in the smoke room, was initiated on 7-15-11 at 10:30pm by the Director of Nursing. The trained employee that is monitoring the smoke break will also be monitored by an assigned staff member that has been trained to audit the smoke monitor, during each designated smoke break for residents, to ensure compliance with the smoke room policy and procedure. Any concerns identifies will be addressed immediately. 4. All new residents will receive a copy of the Smoking Letter that was given to our residents and families by the Admissions Coordinator upon admission to remind them of the smoking policies and procedures.	

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F 323	Continued From page 14 - An observation of a resident smoke break on 07/22/11, at 1:35 PM, revealed oxygen was not being utilized in the smoke room. Observation further revealed Maintenance Employee (ME) #1 was monitoring the resident smoke break. ME #1 stated he received an in-service prior to monitoring a smoke break which included what he should do in case of an emergency, how to use the fire blanket, and was required to give a return demonstration. ME #1 also revealed he had received education on the facility's smoking and oxygen policy. Further observation revealed RN #1 was also present during the resident smoke break. An interview with RN #1 on 07/22/11, at 1:40 PM, revealed she was monitoring the smoke room monitor (ME #1) to ensure residents were safe and the smoking policy was being enforced. The RN was able to identify how to use the fire blanket, fire extinguisher, and the location of both. - A review of the smoke room auditing tool revealed the auditing was initiated on 07/15/11, at 8:45 PM, and every resident smoke break had been monitored since that time. The monitoring included ensuring oxygen was not in the smoking area, aprons were utilized for residents who required aprons, the fire extinguisher, fire blanket, and extra aprons were present in the smoke room, motorized wheelchairs were not present in the smoke room, and the monitor's signature. - An interview conducted with the Administrator on 07/22/11, at 2:30 PM, revealed he was reviewing the smoke break audits daily with the DON to ensure appropriate completion and follow-up as indicated.	F 323	Effective 7-17-11 new admissions and families will also be given a copy of the smoking and contraband policies. 5. The Administrator will initiate daily interdisciplinary team rounds. The comprehensive rounds will address nursing care, nursing documentation, C.N.A care, dietary, environment, room hazards, housekeeping, residents concerns and laundry. <u>Indicate how the facility plans to monitor its performance to ensure that solutions are sustained</u> 1. The Administrator with the Director of Nursing will review the smoke break auditing tool daily for three months to ensure compliance. 2. The Staff Development Coordinator will bring the annual in-service training schedule for emergency preparedness and response to the monthly QA for review and revisions as necessary. 3. The Administrator will review all findings of the interdisciplinary team rounds at the morning meeting. Any issue will be addressed, immediately.	

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F 323	Continued From page 15 - An interview conducted with the Administrator of the facility on 07/22/11, at 4:15 PM, revealed NA #1 was terminated from the facility on 07/20/11. - A review of the personnel file for NA #1 revealed the NA had been terminated from the facility on 07/20/11. Based on the above findings, it was determined the Immediate Jeopardy was removed on 07/19/11. Noncompliance continued with a scope and severity lowered to "D" level based on the facility's need to evaluate the effectiveness of Quality Assurance activities related to the implementation of Policies/Procedures for the Fire/Smoking Safety program.	F 323	All findings will be reported to the QA Committee monthly, with revisions, staff training, and/or disciplinary actions, as needed. Include dates when corrective action will be completed.	08/31/11
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined the facility failed to use its resources effectively and efficiently to attain or maintain the highest practicable physical well-being for residents regarding adequate supervision to prevent accidents for one of twenty-six sampled residents (Resident #1). The Facility Administration failed to have an effective system to ensure policies and procedures were	F 490	F 490 Address what corrective action will be accomplished for those residents found to be affected by the deficient practice/specific corrective action. 1. Administration participated in the investigation of resident #1 who was transferred out of the facility on 7-15-11 to Marcum Wallace Hospital and returned on 7-18-11. Nurse Aide #1 was suspended pending investigation on 7-15-11 and was terminated on 7-20-11. 2. The Administrator instructed the Director of Nursing to in-service staff on the response to an emergency	

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F 490	Continued From page 16 implemented. Administration failed to ensure interventions for safe smoking were implemented, and failed to ensure all staff was trained and knowledgeable of emergency procedures. (Refer to F323 and F518.) On 07/15/11, Resident #1 entered the resident designated smoke room in his/her electric wheelchair while utilizing portable oxygen via nasal cannula. When Resident #1 was finishing his/her cigarette, Nursing Assistant (NA) #1, who was monitoring the smoking room, observed a flash and noted the resident's face/beard was on fire. NA #1 ran from the room to summon the nurse without first attempting to extinguish the fire and ensure residents in the smoke room were protected from further potential injuries. The resident sustained first and second degree burns to the face and blisters to both hands. The facility's failure to have an effective system in place to ensure the facility was administered in a manner that enabled it to use its resources effectively and efficiently caused and was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 07/20/11, and was determined to exist on 07/15/11. The facility was notified on 07/20/11. An acceptable Allegation of Compliance was received on 07/22/11, which alleged removal of Immediate Jeopardy on 07/19/11. The State Agency determined the Immediate Jeopardy was removed on 07/19/11, prior to exit, which lowered the scope and severity to "D" at 42 CFR 483.75 (F490) while the facility monitors the effectiveness of systemic changes and quality assurance activities.	F 490	situation with a fire and with supervision of residents that smoke. The in-service included; Rescue, Alarm, Contain, Evacuate, return demonstration of a resident with and without oxygen; when observed to have the presence of smoke/ fire, of monitoring the smoke break, including reviewing the list of resident specific interventions located in each smoke box and ensuring oxygen equipment does not enter the smoke room. <u>Address how the facility will identify other residents having the potential to be affected by the same deficient practice/Explanation of steps taken to identify other areas of same deficient practice.</u> All resident have the potential to be affected. 1. A thorough investigation was initiated on 7-15-11 by Nurse Kim Henson with further direction from Administrator, Director of Nursing and Social Services Director to determine if any other residents were affected.	

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F 490	Continued From page 17 The findings include: A review of the facility's policy titled "Contraband Discovery-Smoking" policy (dated December 2010) revealed all residents who smoked would require supervision by designated facility staff. The policy further revealed all smoking materials such as lighters, matches, and cigarettes, were required to be kept in the nurses' medication room and facility staff was responsible for lighting resident smoking materials. The policy also revealed smoking would not be permitted in any areas with oxygen related devices. A review of the facility's policy entitled "Fire Classes" (dated January 2005) revealed fire classes would be conducted for all personnel on a quarterly basis. The policy further revealed fire fighting procedures would be included in the class. The policy revealed fire classes would be conducted by the Safety Officer or other responsible person designated by the Administrator. A review of the facility's Incident/Occurrence Investigation dated 07/20/11, revealed Resident #1 had been smoking in the smoke room with his/her oxygen tank on the back of the wheelchair where the oxygen ignited, and caught Resident #1 on fire. RN #4 revealed Resident #1's face and hands were "charred black" and the resident's facial hair was singed. The Investigation further revealed the resident's physician was notified and the resident was transferred by ambulance to the local hospital. A review of the discharge summary from the trauma center dated 07/18/11, revealed Resident #1 had	F 490	2. The Administrator directed that smoking assessments be completed by Rachel Steele, LPN, Della Creech, RN and Teresa Bowman, RN, on 7-15-11 for all residents to ensure that all smoking residents have the appropriate safety interventions in place. 3. Under direction from the Administrator, Stephanie Robinson RT reviewed all residents on 7-15-11 requiring oxygen administration and noted compliance of room signage noting oxygen in use and compliance with oxygen administration. 4. Under the direction of the administrator, on 7-15-11 Social Service Director and DON performed room search for contraband with the residents' permission of all residents. No contraband was found. 5. The administrator advised the Director of Nursing to revise the education material for new and established employees. All active staff members were educated prior to working their scheduled shift.	

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F 490	Continued From page 18 sustained first and second degree burns to the face (eyelids, nose, cheeks, and lips) and blisters to both hands. A review of the facility's Investigation Report completed on 07/20/11, revealed on 07/15/11, at 7:15 PM, Nursing Assistant (NA) #1 was assigned to monitor the resident's smoke break. According to the Investigation Report, Resident #1 entered the facility's designated smoking area in his/her electric wheelchair with an oxygen canister, which was turned on, attached to the back of the wheelchair, and a nasal cannula in his/her nose. The Investigation Report further revealed NA #1 had not observed the nasal cannula and gave Resident #1 a cigarette and proceeded to light the cigarette. The report revealed NA #1 saw smoke and observed Resident #1's facial hair smoking, and then an immediate flash of flame. NA #1 yelled for help and ran out of the room. When staff arrived to the smoke room Resident #1 had put out the fire on his/her face with his/her hands. The Investigation Report revealed upon returning to the smoke room staff observed Resident #1 attempting to put out the fire on the oxygen tubing by using his/her hands. An interview with Resident #1 on 07/19/11, at 1:45 PM, revealed he/she had never been told by facility staff to leave his/her oxygen outside the room. The resident also revealed he/she had taken the oxygen tank into the smoke room numerous times before. An interview conducted with NA #1 on 07/19/11, at 2:25 PM, revealed she had never received in-service training regarding the monitoring of	F 490	Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. 1. The Administrator, DON, and the administrative team received in-service education provided by the Regional Nurse Consultant and VP of Operations on 7/18/11 regarding the requirements of the quality assurance process. The Administrator initiated a process to introduce, develop, and implement process improvement plans for identified concerns on 7/18/11 with the administrative team. Concerns are discussed in the morning meeting daily, and a plan developed with the team to correct the concern using the process improvement plan. The Administrator reviewed the smoke break monitoring system with the Director of Nursing on 7/18/11 to identify that the system ensures that safety precautions are being followed during smoke breaks. 2. The Administrator, Director of Nursing and administrative team will review the orientation process and procedures for new employees and on-	

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F 490	Continued From page 19 residents in the smoke room until after the incident with Resident #1 on 07/15/11. The NA further revealed she had not been told residents could not bring oxygen tanks into the resident smoke room. An interview conducted with the Director of Nursing (DON) on 07/20/11, at 3:00 PM, revealed the Contraband Discovery-Smoking policy was reviewed with all new employees during orientation; however, the facility did not complete competency checks related to monitoring the residents' smoke breaks. The DON stated not bringing oxygen tanks into the smoke room "should be common knowledge." The DON further stated the facility had the employee to sign a check-off sheet to prove they attended the in-service; however the facility offered no pre-test or post-test to ensure the employee was knowledgeable regarding the information given in orientation. The DON stated she just assumed staff had a knowledge base of the information given in orientation. An interview conducted with the Administrator of the facility on 07/20/11, at 4:15 PM, revealed he had not been aware Resident #1 had a cigarette lighter in his/her possession at the time of the incident. The Administrator further revealed the residents were not permitted to enter the resident smoke room with oxygen, nor were they allowed to have cigarette lighters in their possession. The Administrator stated NA #1 should not have allowed the resident into the resident smoke room with the oxygen tank, and also should have taken the cigarette lighter, placed it at the nursing station, and reported the resident's behavior to the nurse. The Administrator revealed staff is	F 490	going training of existing staff. The Interdisciplinary team will discuss and review the disaster/fire safety plan to develop a plan for demonstration and post testing. The Interdisciplinary team will develop an annual in-service training schedule for emergency preparedness and response. 3. The Administrator will initiate daily interdisciplinary team rounds. The comprehensive rounds will address nursing care, nursing documentation, C.N.A care, dietary, environment, room hazards, housekeeping, residents concerns and laundry. <u>Indicate how the facility plans to monitor its performance to ensure that solutions are sustained</u> 1. The Administrator reviews findings of the smoke break audit daily Monday thru Friday with the DON to ensure appropriate completion and follow-up as indicated. Concerns identified will be corrected immediately. 2. The Quality Assurance meeting was held on 7-18-11 by the DON and Administrator. Dr. Santos, Medical	

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F 490	Continued From page 20 required to attend new employee orientation, and then given an annual in-service on the Contraband Discovery-Smoking policy. The Administrator revealed since the incident on 07/15/11, the facility had added a new quality monitor to ensure the resident smoke break monitor was knowledgeable about and following the facility's policy regarding resident smoking. **An acceptable Allegation of Compliance (AOC) was received on 07/22/11, which alleged removal of immediate jeopardy as of 07/19/11. An extended survey was conducted on 07/22/11, which determined the immediate jeopardy was removed on 07/19/11. A review of the Allegation of Compliance revealed the following: - The Administrator, DON, and the Administrative team received an in-service provided by the Regional Nurse Consultant and the VP of Operations on 07/18/11, regarding the requirements of the quality assurance process. - The Quality Assurance Committee met on 07/18/11, to review the performance improvement plan and for further recommendations. - The VP of Operations or the Regional Nurse Consultant would be providing oversight daily. **The Allegation of Compliance was verified by the following: - A review of educational rosters dated 07/18/11, revealed the Administrator, DON, and the administrative team (Unit Managers, MDS Nurses, Social Services, Activity Director, Medical	F 490	Director, was in attendance as well as Plant Ops director, Medical Records, the MDS coordinators, the Unit Managers, the HR Director, SSD, Dietary Manager, Housekeeping Director, Rehab Services Manager and the Activities Director to review the performance improvement plan and for further recommendation. The smoking, oxygen and fire safety policies including the contraband policy and procedures were reviewed. The PI plan was approved by the Quality Assurance committee and Dr. Santos the medical director. All findings of the stated audits and review of the policies will be presented to the Quality Assurance Committee each week for four weeks, then monthly for further recommendations and follow up. 3. The administrator will oversee the QA committee meeting in conjunction with the Director of Nursing, IDT team and Medical Director. Keith Boyce, VP of Operations, or the Regional Nurse Consultant will provide oversight daily, Monday – Friday, starting 07/18/11 for one (1) week; then, once per week for four (4) weeks and then monthly for three (3)months of the	

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F 490	Continued From page 21 Records, Dietary Manager, Staff Development Coordinator, Housekeeping Supervisor, Maintenance Director, and Medical Director) were educated by the Regional Vice President and Regional Nurse Consultant regarding the QA process related to the smoke break monitoring system and to ensure that safety precautions were followed. An interview conducted with the Administrator on 07/22/11, at 2:30 PM, revealed the Administrator was reviewing the smoke break audit daily with the DON to ensure appropriate completion and follow-up as indicated. - A review of the minutes for a Quality Assurance meeting conducted on 07/18/11, revealed the Administrator, DON, and Medical Director, as well as the Plant Operations Director, Housekeeping Supervisor, and other Department Managers reviewed the Performance Improvement Plan which included findings of stated audits and the smoking, oxygen, fire safety, and contraband policy and procedures. The minutes also revealed the QA Committee would review the policies weekly for four weeks and then monthly for three months to ensure compliance. - An interview conducted with the Regional Nurse Consultant on 07/22/11, at 4:00 PM, revealed the Vice President of Operations or the Regional Nurse Consultant was providing oversight daily beginning on 07/18/11, and would continue for one week, then once weekly for four weeks, and then monthly for three months. Based on the above findings, it was determined the Immediate Jeopardy was removed on 07/19/11. Noncompliance continued with scope and severity lowered to "D" level based on the	F 490	Administration and operations. 4. The Regional Nurse will observe the Staff Development during orientation of new employees for monitoring of education for emergency preparedness and response, once during the next month. Thereafter, the director of nursing or the administrator will observe the orientation process once a month on an on-going basis. All findings will be discussed at the monthly QA committee, with system revisions, and further recommendation as needed. 5. The Interdisciplinary team will review the annual in-service training schedule for emergency preparedness and response each month with the QA committee with revisions as necessary. 6. During the morning meeting the Interdisciplinary team round findings with be discussed with the administrative team and a process improvement implemented for any concerns. All findings will be discussed at the monthly QA committee, with system revisions, and further recommendation as needed.	

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F 490	Continued From page 22 facility's need to evaluate the effectiveness of Quality Assurance activities related to the implementation of Policies/Procedures for the Fire/Smoking Safety program.	F 490	Include dates when corrective action will be completed.	08/31/11
F 518 SS=J	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, it was determined the facility failed to have an effective system to ensure all employees were trained in emergency procedures to include monitoring of resident smoke breaks. On 07/15/11, one of twenty-six sampled residents (Resident #1) entered the resident smoke room with portable oxygen attached to his/her electric wheelchair. The oxygen was on and the resident was receiving the oxygen via nasal cannula. NA #1, who was monitoring the smoke room, provided Resident #1 with a cigarette and light. The NA observed the resident relight his/her cigarette with a lighter he/she was carrying. When the resident was finishing his/her cigarette, the oxygen ignited, causing the resident's face and beard to catch on fire. The NA ran from the room to summon help and did not attempt to extinguish the fire or ensure residents were protected from further potential harm. (Refer to F323.)	F 518	F 518 Address what corrective action will be accomplished for those residents found to be affected by the deficient practice/specific corrective action. 1. Kim Henson, RN, initiated staff education on 7-15-11 at approximately 7:45 pm on the smoking policy, including oxygen is not allowed in the smoke room, for the facility staff that were present in the building at the time of the incident. Mary Deaton, C.N.A, Staffing Coordinator, called remaining facility staff at 9:30 pm on 7-15-11 to the facility for education on the smoking policy to include oxygen not allowed in smoking room. Address how the facility will identify other residents having the potential to be affected by the same deficient practice/Explanation of steps taken to identify other areas of same deficient practice. 1. After review of education provided by Kim Henson, RN on 7-15-11, the	

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F 518	Continued From page 23 Based on the above findings, it was determined the facility's failure to have an effective system in place to ensure employees were adequately trained in emergency procedures related to fire, caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 07/20/11, and was determined to exist on 07/15/11. The facility was notified on 07/20/11. An acceptable Allegation of Compliance was received on 07/22/11, which alleged removal of Immediate Jeopardy on 07/19/11. The State Agency determined the Immediate Jeopardy was removed on 07/19/11, prior to exit, which lowered the scope and severity to "D" at 42 CFR 483.75 (F518) while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: A review of the facility's policy entitled "Fire Classes" (dated January 2005) revealed fire classes would be conducted for all personnel on a quarterly basis. The policy further revealed fire fighting procedures would be included in the class. The policy revealed fire classes would be conducted by the Safety Officer or other responsible person designated by the Administrator. A review of the facility policy entitled "Contraband Discovery-Smoking" (dated December 2010) revealed residents who smoke were required to be supervised by designated facility staff. The policy revealed all smoking materials were required to be kept in the nurses' medication	F 518	Director of Nursing revised the education material and began to in-service the staff on 7-16-11 at 5am with return demonstration of a resident with and without oxygen, when observed to have the presence of smoke and/or fire, of monitoring the smoke break, including reviewing the list of resident specific interventions located in each smoke box and ensuring that oxygen equipment does not enter the smoke room. This in-servicing also included RACE: Rescue, Alarm, Contain, Evacuate and what to do in an emergency situation. The educational in-services continued throughout the day by the Director of Nursing, Jennifer Pelfrey, RN and Denise Lynch, Consumer Relations. All active staff members were educated prior to working their scheduled shift. 2. On 7-18-11, the Director of Maintenance in-serviced active staff on the fire safety policy and procedure. 3. The Administrator, Director of Nursing and administrative team will review the orientation process and procedures for new employees and on-going training of existing staff. The Interdisciplinary team will discuss and	

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F 518	Continued From page 24 room. The policy further stated the facility staff was required to light resident smoking material. The policy revealed smoking would not be permitted in areas with any oxygen related devices. The facility did not provide a policy related to new employee orientation. The facility also did not provide a policy related to monitoring resident smoke breaks. A review of the facility's Incident/Occurrence Investigation completed on 07/20/11, revealed Resident #1 had been smoking in the smoke room with his/her oxygen tank on the back of the wheelchair when the oxygen ignited, and caught Resident #1 on fire. RN #4 revealed Resident #1's face and hands were "charred black" and the resident's facial hair was singed. Per the report, Resident #1 sustained first and second degree burns to the face (eyelids, nose, cheeks, and lips) and blisters to both hands. A review of the facility's Investigation Report completed on 07/20/11, revealed Nursing Assistant (NA) #1 had been assigned to monitor the resident smoke room for a smoke break. The Investigation Report further revealed NA #1 had not seen the oxygen tubing, nor did she realize the oxygen was still on. NA #1 gave Resident #1 a cigarette and proceeded to light the cigarette. The Report revealed NA #1 saw smoke and the facial hair of Resident #1 on fire, and then an immediate flash of flame. The Report revealed NA #1 yelled for help, ran out of the room to the nurses' station to get help, did not attempt to extinguish the fire on the resident's face, and failed to ensure residents were protected from	F 518	review the disaster/fire safety plan to develop a plan for demonstration and post testing. The Interdisciplinary team will develop an annual in-service training schedule for emergency preparedness and response. <u>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</u> 1. Safety/Awareness to prevent accidents/hazards has been revised by the Administrator, Director of Nursing, HR Director and Staff Development Coordinator and has been added to orientation of all new employees as of July 17, 2011. This includes education on RACE, the smoking policies and procedures, monitoring the smoke room and safety procedures and oxygen and fire safety. The new packet will include post test for all new hires effective 7-17-11 with return demonstration of turning off oxygen, throwing the fire blanket on the flame, pulling the fire alarm to alert other staff for need of rescue and possible evacuation. 2. The Interdisciplinary team discussed	

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F 518	Continued From page 25 further harm. An interview conducted with NA #1 on 07/19/11, at 2:25 PM, revealed she monitored the resident's smoke breaks on most of the shifts she worked. The NA stated the only in-service she had received since employment, regarding monitoring resident smoke breaks and what to do in an emergency situation, was after the incident with Resident #1. The NA stated all she had been told regarding residents' smoke breaks was that the residents could only have two cigarettes per smoke break. Per interview, when Resident #1's oxygen ignited, NA #1 screamed for help and left the smoke room to get a nurse, leaving two residents in the smoke room alone (Residents #1 and #25). The NA stated she did not know what to do and just panicked. An interview conducted with the Staff Development Coordinator (SDC) on 07/20/11, at 3:50 PM, revealed she was responsible for the educational in-services for the staff. The SDC stated policies were reviewed; however, there was so much information to cover, the in-service was general. The SDC further stated she showed the employees where the fire blanket was kept in the resident smoke room, but did not demonstrate to the employees how to use the fire blanket or when to use it. The SDC further revealed the fire blanket was not mentioned in any of the facility's fire safety policies, but was kept for use in the resident smoke room. The SDC revealed she did not complete any competencies to assess the new employees' knowledge of the information she presented in new employee orientation. The SDC further stated the facility provided no special in-services	F 518	and reviewed the disaster/fire safety plan to develop a plan for demonstration and post testing. The Interdisciplinary team will develop an annual in-service training schedule for emergency preparedness and response. 3. The Staff Development Coordinator will develop and initiate post testing for emergency procedures and preparedness. Training will be completed for new employees during orientation process and on-going for existing staff as scheduled on the emergency preparedness training calendar. <u>Indicate how the facility plans to monitor its performance to ensure that solutions are sustained</u> 1. The Director of Nursing or the Regional Nurse Consultant will monitor the Staff Development Coordinator once per month for the next three months during orientation of new employees. The Director of Nursing or Regional Nurse Consultant will document any findings, address any corrective action immediately and re-educate if needed. All findings will be brought to QA monthly for revision,	

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F 518	Continued From page 26 to staff assigned to monitor the resident smoke room prior to the incident with Resident #1 on 07/15/11. An interview on 07/20/11, at 3:35 PM, with the facility's Maintenance Director (MD) revealed he was responsible for conducting in-services on fire safety. The MD stated the training he provided was not part of new employee orientation. Per interview, he told employees where the fire blanket was stored but did not instruct staff on how to use the fire blanket. The MD stated there could potentially be some employees who did not know how to use the fire blanket because the last in-service conducted on fire safety was on 03/17/11. The MD further stated the fire blanket should have been used for the incident with Resident #1 on 07/15/11. Per interview, the MD felt fire safety training was very important and someone could potentially die if the staff did not know fire safety. A review of the personnel file for NA #1 revealed the NA was hired on 04/01/11, and attended orientation on 04/01/11. The in-service record for NA #1 revealed on 04/01/11, NA #1 attended Fire/Disaster Safety and Risk Management Accident/Incident in-services provided by the SDC during the routine new employee orientation. **An acceptable Allegation (AOC) of Compliance was received on 07/22/11, which alleged removal of Immediate Jeopardy on 07/19/11. An extended survey was conducted on 07/22/11, which determined the Immediate Jeopardy was removed on 07/19/11. A review of the Allegation of Compliance revealed the following:	F 518	if needed. 2. The Staff Development Coordinator will bring the in-service calendar and post test for all in-services scheduled for that month to the QA meeting. The QA committee will review and discuss the material and the post test for any changes that may be needed. Include dates when corrective action will be completed.	08/31/11

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F 518	Continued From page 27 - In-services began on 07/15/11, and all staff would be educated prior to working their next scheduled shift. In-services included monitoring residents' smoke break; smoking policy including oxygen not being allowed in the smoke room; safety interventions with a return demonstration of what to do in the presence of smoke and/or fire; what to do in an emergency situation; and where to find resident specific interventions to be implemented when smoking. - The Safety Awareness in-service to prevent accidents, including education on the facility's smoking policies and procedures, monitoring the smoke room, and oxygen and fire safety, has been revised by the Administrator, DON, Human Resources Director, and SDC, and added to the orientation agenda beginning 07/17/11. **The Allegation of Compliance was verified by the following: - A review of the education rosters revealed education was initiated on 07/15/11, and facility staff was in-serviced on the process to monitor scheduled smoke breaks/safety procedures with return demonstrations of emergency interventions prior to working their next shift. Interviews on 07/22/11, between 1:30 PM and 4:00 PM, with State Registered Nursing Assistants (SRNAs) #6, #12, and #13, Housekeeper #13, Licensed Practical Nurse #3, and RN #2 revealed staff was able to confirm fire/oxygen safety education had been provided and all staff was able to relate the appropriate emergency interventions that should be provided in the event of an emergency. Observations in the smoke room on 07/22/11, at 1:30 PM, revealed ME #1 and RN #1 were able to	F 518		

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F 518	Continued From page 28 demonstrate the use of the fire blanket and location of the fire extinguisher. - A review of the orientation agenda regarding Safety/Awareness to prevent accidents/hazards revealed the agenda had been revised and added to the orientation of all new employees. This included education on RACE, smoking policies/procedures, monitoring the smoke room and safety procedures, and oxygen and fire safety. The new packet included pre and post tests for all newly hired employees with return demonstrations required for shutting off oxygen, placing the fire blanket on the flames, pulling the fire alarm, and possible evacuation. Based on the above findings, it was determined the Immediate Jeopardy was removed on 07/19/11. Noncompliance continued with scope and severity lowered to "D" level based on the facility's need to evaluate the effectiveness of Quality Assurance activities related to the implementation of Policies/Procedures for the Fire/Smoking Safety program.	F 518		