STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 02/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEEWOOD HEALTHCARE CENTER	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(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 An unannounced Medicare/Medicaid abbreviated survey was conducted on 2/13/19. One Complaint was investigated during the survey. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The census in this 132 certified bed facility was 123 at the time of the survey. The survey sample consisted of 1 current resident reviews (Resident #1).	F 000	This Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statements made in the Plan of Correction cannot be used against the facility in any subsequent administrative or civil proceeding.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, for Resident #1, the facility staff failed to ensure the accuracy of Minimum Data Assessments to include tobacco use that resulted in a fire in the resident's bed. The facility staff failed to ensure the accuracy of Resident #1's MDS assessments on 1/17/19, and 10/2/18 to include tobacco use that resulted in a fire in the resident's bed on 2/5/19. The Findings included: Resident #1 was a 90 year old who was admitted to the facility on 8/14/14. His diagnoses included Muscle Weakness, Other Lack of Coordination,	F 641	**F 641 Accuracy of Assessments** Compliance Date: 3/4//19 **Immediate action taken for the resident found to have been affected include:** Resident #1's MDS assessment was updated on 2/13/19 to include tobacco use. **Identification of other residents having the potential to be affected.** No other residents have the potential to be affected as resident #1 was the only tobacco user in the facility.	3/4/19

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

T K | Administrator | 3/8/19

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 641	Continued From page 1 Peripheral Vascular Disease, Type 2 Diabetes with Diabetic Neuropathy, Depression and Anxiety Disorder. The Minimum Data Set, which was an Annual Assessment with an Assessment Reference Date of 1/17/19 was reviewed. It coded Resident #1 as having a Brief Interview of Mental Status Score of 15, indicating that he was cognitively intact. In addition, Resident #1 was coded as requiring the physical assistance of 1 person for eating and dressing. In Section J, Resident #1 was incorrectly coded as having no tobacco use. In addition, in the Quarterly Assessment dated 10/2/18, Section J, the facility failed to document his tobacco use. On 2/13/19, at 1:45 P.M. an observation was made of Resident #1 who was alone in his room. He was not being supervised by facility staff. He was in his wheelchair, and reached up over his bed and grabbled the metal triangle apparatus. He then pulled himself into bed from his wheelchair. He had cotton gloves on both hands that had the top half of gloves cut off, exposing the tips of his fingers. The gloves appeared to be old, worn and soiled with debris. Resident #1 stated that he wore the gloves all of the time "because they support my hands". Resident #1 was asked how the fire started in his bed. He stated that since his admission to the facility, he smoked during scheduled smoking breaks at 8 A.M., 12 Noon, 4 P.M., and 8 P.M. He stated that staff sometimes didn't put a smoking apron on him. When asked specifically about the night of the fire on 2/5/19, Resident #1 stated, "They didn't give me a smoking apron that night. If I had that apron I would not have had the fire.	F 641	**Actions taken/systems put into place to reduce the risk of future occurrence.** Education, in-service program was conducted for MDS nurses by Administrator on 3/4/19 regarding properly coding tobacco use on MDS assessments. **How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing/Designee will review MDS assessments for residents who use tobacco to ensure the assessment accurately reflects resident's status, weekly for 4 weeks then monthly for 2 months.	

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F 641	Continued From page 2 The embers got on my blanket covering my wheelchair. I always have 2 blankets covering my chest, legs and feet. After smoking that night, I got in bed and went to sleep. I didn't know my bed was on fire." On 2/13/19, a review was conducted of facility documentation, revealing a Facility Reported Incident dated 2/5/19. It read, "On February 5, 2019 at approximately 10:40 p.m., smoke was observed coming from [Resident #1's] room. Staff opened the door and saw smoke and fire originating from residents' bed. Staff evacuated resident from room, fire alarm was sounded, and fire was put out by staff using fire extinguisher. Fire department arrived and reviewed situation. [Resident #1] was assessed by staff and EMS; no injuries or concerns noted, transfer to the hospital was not necessary based on assessment and physicians agreement. [Resident #1] was grandfathered and is the only resident with smoking privileges. His last smoke break was at 8:30 pm where he was supervised by staff. Order for nicotine patch was obtained and patch was placed on resident today." The facility documentation contained statements by the staff who smelled the smoke, and by the Certified Nursing Assistant (Employee B), who extinguished the fire. The facility Director of Nursing (Employee A) identified Employee B as the staff person who was responsible for supervising Resident #1 during his smoking break just prior to the fire. The investigation did not contain any information from Employee B regarding the smoking break. There was no statement in the investigation from Employee B that he had put a smoking apron on Resident #1 on 2/5/19. There was no statement from	F 641	The Director of Nursing/Designee will present the results of reviews to the Quality Assurance Performance Improvement Committee for review and further recommendations. Quality Assurance Performance Improvement Team Members include: Administrator, Director of Nursing, Staff Development Coordinator, Director of Social Services, Director of Dietary, Director of Housekeeping, Director of Maintenance, Nurse Managers, Minimum Data Set Coordinator, Medical Director, Director of Rehab Services, and Pharmacy Consultant. If issues are identified, then additional education will be provided and modification of the Plan of Correction will be made to address the deficient practice.	

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F 641	Continued From page 3 Employee B that he provided supervision by ensuring that Resident #1 did not have any smoldering embers from cigarette use on his blankets prior to Resident #1 leaving the courtyard and putting himself in bed. Employee B submitted three conflicting statements (2 written, and 1 verbal). The first statement dated 2/5/19 read, "Around 10:50 pm when I was doing my initial rounds, I notice smoke coming from [Resident's room] and immediately rushed into the room and realized that the whole room was covered with smoke from the mattress and blankets. I immediately followed the facility protocol." Employee B's second statement was received via a telephone interview with this Surveyor on 2/13/19 at 3:30 P.M. When asked to describe what happened the night of the fire, he stated, "I got the cigarettes and lighter from the nurse and medication cart. I put the bib on him. He normally has blankets on him because it's cold outside. After he smoked 2 cigarettes, I took off the bib and blanket and made sure nothing was in the blanket." When asked to describe the "bib", Employee E hesitated, then stated, "It's the bib we use to feed residents. That's the one I used on that day, it's brown." When asked again to specifically describe the item he used, Employee B stated again, "It's the brown bib we always use to feed that residents." Employee E was unable to describe a smoking apron. The surveyor confirmed with the Director of Nursing (Employee A) that the brown clothing protectors on the unit were used for every resident, and that they were not smoking aprons. The facility staff was not able to show the	F 641		

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F 641	Continued From page 4 surveyor Resident #1's smoking apron. The DON stated that Resident #1 had a gray smoking apron that had been discarded. The manufacturer's instructions for the brown clothing protector read, "Adult Clothing Protector. Made of heavy domestic terry cloth. 50/50 cotton polyester blend." The clothing protector was not fire retardant. Employee B's third statement was submitted via email at the request of the Facility Administrator (Employee C), who was not present in the facility during the survey. The third statement was dated 2/14/19. It read, "On 2/5/19 at around 8:30 pm, I took (Resident #1) of room 170 out in the courtyard so he can have his routine smoke of cigarettes. As usual I put on his smoking apron over him first as I stand and watch. After he finished the first which I gave, the half was trashed into the cigarette (ashtray) and so for the second one too. As always sure that the apron and blankets were taken off him before taking him into his room and put him in his bed and get him clean. I have been working with him for three years and am very conversant with smoking routine and the facility's policy with regards that. On 2/13/19, I received a call from somebody working for the State board and wanted to ask me some questions about the fire accident that took placed on 2/5/19 whilst I was working at Dogwood evening shift. I was asked specifically about the type and color apron I used on [Resident # 1] when I took him out to smoke on the above mentioned date, and my reply was, his smoking apron that he usually use for smoking, was not sure about the color."	F 641		

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F 641	Continued From page 5 On 2/13/19 a review was conducted of Resident #1's clinical record, revealing a 4 year old Activities care plan dated 7/8/15. It read, "Often buys cigarettes, alcohol and lighters when on outings and refuses to allow the activity aide to hold items. He hides lighters and cigarettes in his gloves and becomes aggressive when facility staff request to lock them up for his safety." Resident #1's care plan did not address smoking safety again until after the fire in his bed occurred on 2/5/19. The current care plan read, "Resident brought some ashes to the room and burned some parts of his bed. Monitoring and searches for cigarettes and lighter. Verbal reminders. One on one sitter provided." According to the progress notes, Resident #1 had one on one supervision until 2/8/19. There was no documentation in the progress notes that the one on one supervision had been discontinued. The care plan did not document the discontinuance of one on one supervision. Prior to the fire, Resident # 1 had the following signed physician's orders, "Resident may smoke with staff 2 times in morning and 2 times in the evening." Resident #1's clinical record contained only one Safe Smoking Needs Assessment dated 1/3/19. It read, "Apply Smoking Apron". The facility Smoking Policy, dated 10/3/17 read, "Residents will not be permitted to smoke without the direct supervision of a responsible staff member or volunteer. Direct supervision must be provided throughout the entire smoking period. All residents who smoke will be assessed upon	F 641		

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F 641	Continued From page 6 admission, quarterly, and PRN (as needed) as conditions warrants for safety equipment needs. Examples of equipment include smoking aprons and assistive devices. On 2/13/19 at 3:45 P.M. the Director of Nursing was informed of the findings.	F 641	**F 656 Develop/Implement Comprehensive Care Plan** Compliance Date: 3/8/19 **Immediate action taken for the resident found to have been affected include:**	3/8/19
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	F 656	Resident #1's smoking safety care plan was updated on 3/8/19 by the Nursing Unit Manager. **Identification of other residents having the potential to be affected.** No other residents have the potential to be affected as resident #1 was the only tobacco user in the facility. **Actions taken/systems put into place to reduce the risk of future occurrence.** Education, in-service program was conducted for Nurse Unit Managers by Administrator on 3/8/19 regarding properly developing Smoking Safety care plans for residents who are allowed to smoke at the facility.	

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F 656	Continued From page 7 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, for Resident #1, the facility staff failed to develop a Smoking Safety care plan to prevent a fire in the resident's bed. The facility staff failed to ensure that Resident #1 (who had a documented history of hiding lighters and cigarette in his gloves), had a Smoking Safety care plan to prevent a fire in the resident's bed on 2/5/19. The Findings included: Resident #1 was a 90 year old who was admitted to the facility on 8/14/14. His diagnoses included Muscle Weakness, Other Lack of Coordination, Peripheral Vascular Disease, Type 2 Diabetes with Diabetic Neuropathy, Depression and Anxiety Disorder. The Minimum Data Set, which was an Annual Assessment with an Assessment Reference Date of 1/17/19 was reviewed. It coded Resident #1 as	F 656	**How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing/Designee will review care plans for residents who are allowed to smoke at the facility to ensure a comprehensive care plan is implemented, weekly for 4 weeks then monthly for 2 months. The Administrator/Designee will present the results of reviews to the Quality Assurance Performance Improvement Committee for review and further recommendations. Quality Assurance Performance Improvement Team Members include: Administrator, Director of Nursing, Staff Development Coordinator, Director of Social Services, Director of Dietary, Director of Housekeeping, Director of Maintenance, Nurse Managers, Minimum Data Set Coordinator, Medical Director, Director of Rehab Services, and Pharmacy Consultant. If issues are identified, then additional education will be provided and modification of the Plan of Correction will be made to address the deficient practice	

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F 656	Continued From page 8 having a Brief Interview of Mental Status Score of 15, indicating that he was cognitively intact. In addition, Resident #1 was coded as requiring the physical assistance of 1 person for eating and dressing. In Section J, Resident #1 was incorrectly coded as having no tobacco use. In addition, in the Quarterly Assessment dated 10/2/18, Section J, the facility failed to document his tobacco use. On 2/13/19, at 1:45 P.M. an observation was made of Resident #1 who was alone in his room. He was not being supervised by facility staff. He was in his wheelchair, and reached up over his bed and grabbled the metal triangle apparatus. He then pulled himself into bed from his wheelchair. He had cotton gloves on both hands that had the top half of gloves cut off, exposing the tips of his fingers. The gloves appeared to be old, worn and soiled with debris. Resident #1 stated that he wore the gloves all of the time "because they support my hands". Resident #1 was asked how the fire started in his bed. He stated that since his admission to the facility, he smoked during scheduled smoking breaks at 8 A.M., 12 Noon, 4 P.M., and 8 P.M. He stated that staff sometimes didn't put a smoking apron on him. When asked specifically about the night of the fire on 2/5/19, Resident #1 stated, "They didn't give me a smoking apron that night. If I had that apron I would not have had the fire. The embers got on my blanket covering my wheelchair. I always have 2 blankets covering my chest, legs and feet. After smoking that night, I got in bed and went to sleep. I didn't know my bed was on fire." On 2/13/19, a review was conducted of facility	F 656		

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F 656	Continued From page 9 documentation, revealing a Facility Reported Incident dated 2/5/19. It read, "On February 5, 2019 at approximately 10:40 p.m., smoke was observed coming from [Resident #1's] room. Staff opened the door and saw smoke and fire originating from residents' bed. Staff evacuated resident from room, fire alarm was sounded, and fire was put out by staff using fire extinguisher. Fire department arrived and reviewed situation. [Resident #1] was assessed by staff and EMS; no injuries or concerns noted, transfer to the hospital was not necessary based on assessment and physicians agreement. [Resident #1] was grandfathered and is the only resident with smoking privileges. His last smoke break was at 8:30 pm where he was supervised by staff. Order for nicotine patch was obtained and patch was placed on resident today." The facility documentation contained statements by the staff who smelled the smoke, and by the Certified Nursing Assistant (Employee B), who extinguished the fire. The facility Director of Nursing (Employee A) identified Employee B as the staff person who was responsible for supervising Resident #1 during his smoking break just prior to the fire. The investigation did not contain any information from Employee B regarding the smoking break. There was no statement in the investigation from Employee B that he had put a smoking apron on Resident #1 on 2/5/19. There was no statement from Employee B that he provided supervision by ensuring that Resident #1 did not have any smoldering embers from cigarette use on his blankets prior to Resident #1 leaving the courtyard and putting himself in bed.	F 656		

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F 656	Continued From page 10 Employee B submitted three conflicting statements (2 written, and 1 verbal). The first statement dated 2/5/19 read, "Around 10:50 pm when I was doing my initial rounds, I notice smoke coming from [Resident's room] and immediately rushed into the room and realized that the whole room was covered with smoke from the mattress and blankets. I immediately followed the facility protocol." Employee B's second statement was received via a telephone interview with this Surveyor on 2/13/19 at 3:30 P.M. When asked to describe what happened the night of the fire, he stated, "I got the cigarettes and lighter from the nurse and medication cart. I put the bib on him. He normally has blankets on him because it's cold outside. After he smoked 2 cigarettes, I took off the bib and blanket and made sure nothing was in the blanket." When asked to describe the "bib", Employee E hesitated, then stated, "It's the bib we use to feed residents. That's the one I used on that day, it's brown." When asked again to specifically describe the item he used, Employee B stated again, "It's the brown bib we always use to feed that residents." Employee E was unable to describe a smoking apron. The surveyor confirmed with the Director of Nursing (Employee A) that the brown clothing protectors on the unit were used for every resident, and that they were not smoking aprons. The facility staff was not able to show the surveyor Resident #1's smoking apron. The DON stated that Resident #1 had a gray smoking apron that had been discarded. The manufacturer's instructions for the brown clothing protector read, "Adult Clothing Protector. Made of heavy domestic terry cloth. 50/50 cotton polyester	F 656		

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F 656	Continued From page 11	F 656		

blend." The clothing protector was not fire retardant.

Employee B's third statement was submitted via email at the request of the Facility Administrator (Employee C), who was not present in the facility during the survey. The third statement was dated 2/14/19. It read, "On 2/5/19 at around 8:30 pm, I took (Resident #1) of room 170 out in the courtyard so he can have his routine smoke of cigarettes. As usual I put on his smoking apron over him first as I stand and watch. After he finished the first which I gave, the half was trashed into the cigarette (ashtray) and so for the second one too. As always sure that the apron and blankets were taken off him before taking him into his room and put him in his bed and get him clean.

I have been working with him for three years and am very conversant with smoking routine and the facility's policy with regards that.

On 2/13/19, I received a call from somebody working for the State board and wanted to ask me some questions about the fire accident that took placed on 2/5/19 whilst I was working at Dogwood evening shift. I was asked specifically about the type and color apron I used on [Resident # 1] when I took him out to smoke on the above mentioned date, and my reply was, his smoking apron that he usually use for smoking, was not sure about the color."

On 2/13/19 a review was conducted of Resident #1's clinical record, revealing a 4 year old Activities care plan dated 7/8/15. It read, "Often buys cigarettes, alcohol and lighters when on outings and refuses to allow the activity aide to

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F 656	Continued From page 12 hold items. He hides lighters and cigarettes in his gloves and becomes aggressive when facility staff request to lock them up for his safety." Resident #1's care plan did not address smoking safety again until after the fire in his bed occurred on 2/5/19. The current care plan read, "Resident brought some ashes to the room and burned some parts of his bed. Monitoring and searches for cigarettes and lighter. Verbal reminders. One on one sitter provided." According to the progress notes, Resident #1 had one on one supervision until 2/8/19. There was no documentation in the progress notes that the one on one supervision had been discontinued. The care plan did not document the discontinuance of one on one supervision. Prior to the fire, Resident # 1 had the following signed physician's orders, "Resident may smoke with staff 2 times in morning and 2 times in the evening." Resident #1's clinical record contained only one Safe Smoking Needs Assessment dated 1/3/19. It read, "Apply Smoking Apron". The facility Smoking Policy, dated 10/3/17 read, "Residents will not be permitted to smoke without the direct supervision of a responsible staff member or volunteer. Direct supervision must be provided throughout the entire smoking period. All residents who smoke will be assessed upon admission, quarterly, and PRN (as needed) as conditions warrants for safety equipment needs. Examples of equipment include smoking aprons and assistive devices. On 2/13/19 at 3:45 P.M. the Director of Nursing	F 656		

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F 656	Continued From page 13 was informed of the findings.	F 656	**F 689 Free of Accident Hazards/Supervision/Devices**	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, for Resident #1, the facility staff failed to provide adequate supervision and equipment to prevent a fire in the resident's bed. The facility staff failed to ensure that Resident #1 had a smoking apron used during a smoking break on 2/5/19 at 8:00 P.M. The Findings included: Resident #1 was a 90 year old who was admitted to the facility on 8/14/14. His diagnoses included Muscle Weakness, Other Lack of Coordination, Peripheral Vascular Disease, Type 2 Diabetes with Diabetic Neuropathy, Depression and Anxiety Disorder. The Minimum Data Set, which was an Annual Assessment with an Assessment Reference Date of 1/17/19 was reviewed. It coded Resident #1 as having a Brief Interview of Mental Status Score of	F 689	Compliance Date: 3/22/19 **Immediate action taken for the resident found to have been affected include:** Resident #1 was given a Nicotine patch and is no longer smoking cigarettes. **Identification of other residents having the potential to be affected.** No other residents have the potential to be affected as resident #1 was the only smoker in the facility. **Actions taken/systems put into place to reduce the risk of future occurrence.** Education was initiated with all nursing staff regarding the importance of the proper smoking apron being used.	3/22/19

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F 689	Continued From page 14 15, indicating that he was cognitively intact. In addition, Resident #1 was coded as requiring the physical assistance of 1 person for eating and dressing. In Section J, Resident #1 was incorrectly coded as having no tobacco use. In addition, in the Quarterly Assessment dated 10/2/18, Section J, the facility failed to document his tobacco use. On 2/13/19, at 1:45 P.M. an observation was made of Resident #1 who was alone in his room. He was not being supervised by facility staff. He was in his wheelchair, and reached up over his bed and grabbled the metal triangle apparatus. He then pulled himself into bed from his wheelchair. He had cotton gloves on both hands that had the top half of gloves cut off, exposing the tips of his fingers. The gloves appeared to be old, worn and soiled with debris. Resident #1 stated that he wore the gloves all of the time "because they support my hands". Resident #1 was asked how the fire started in his bed. He stated that since his admission to the facility, he smoked during scheduled smoking breaks at 8 A.M., 12 Noon, 4 P.M., and 8 P.M. He stated that staff sometimes didn't put a smoking apron on him. When asked specifically about the night of the fire on 2/5/19, Resident #1 stated, "They didn't give me a smoking apron that night. If I had that apron I would not have had the fire. The embers got on my blanket covering my wheelchair. I always have 2 blankets covering my chest, legs and feet. After smoking that night, I got in bed and went to sleep. I didn't know my bed was on fire." On 2/13/19, a review was conducted of facility documentation, revealing a Facility Reported	F 689	**How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing/Designee will review smoking apron use for all smoking residents, weekly for 4 weeks then monthly for 2 months. The Administrator/Designee will present the results of reviews to the Quality Assurance Performance Improvement Committee for review and further recommendations. Quality Assurance Performance Improvement Team Members include: Administrator, Director of Nursing, Staff Development Coordinator, Director of Social Services, Director of Dietary, Director of Housekeeping, Director of Maintenance, Nurse Managers, Minimum Data Set Coordinator, Medical Director, Director of Rehab Services, and Pharmacy Consultant. If issues are identified, then additional education will be provided and modification of the Plan of Correction will be made to address the deficient practice	

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F 689	Continued From page 15 Incident dated 2/5/19. It read, "On February 5, 2019 at approximately 10:40 p.m., smoke was observed coming from [Resident #1's] room. Staff opened the door and saw smoke and fire originating from residents' bed. Staff evacuated resident from room, fire alarm was sounded, and fire was put out by staff using fire extinguisher. Fire department arrived and reviewed situation. [Resident #1] was assessed by staff and EMS; no injuries or concerns noted, transfer to the hospital was not necessary based on assessment and physicians agreement. [Resident #1] was grandfathered and is the only resident with smoking privileges. His last smoke break was at 8:30 pm where he was supervised by staff. Order for nicotine patch was obtained and patch was placed on resident today." The facility documentation contained statements by the staff who smelled the smoke, and by the Certified Nursing Assistant (Employee B), who extinguished the fire. The facility Director of Nursing (Employee A) identified Employee B as the staff person who was responsible for supervising Resident #1 during his smoking break just prior to the fire. The investigation did not contain any information from Employee B regarding the smoking break. There was no statement in the investigation from Employee B that he had put a smoking apron on Resident #1 on 2/5/19. There was no statement from Employee B that he provided supervision by ensuring that Resident #1 did not have any smoldering embers from cigarette use on his blankets prior to Resident #1 leaving the courtyard and putting himself in bed. Employee B submitted three conflicting	F 689		

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F 689	Continued From page 16	F 689		

statements (2 written, and 1 verbal). The first statement dated 2/5/19 read, "Around 10:50 pm when I was doing my initial rounds, I notice smoke coming from [Resident's room] and immediately rushed into the room and realized that the whole room was covered with smoke from the mattress and blankets. I immediately followed the facility protocol."

Employee B's second statement was received via a telephone interview with this Surveyor on 2/13/19 at 3:30 P.M. When asked to describe what happened the night of the fire, he stated, "I got the cigarettes and lighter from the nurse and medication cart. I put the bib on him. He normally has blankets on him because it's cold outside. After he smoked 2 cigarettes, I took off the bib and blanket and made sure nothing was in the blanket." When asked to describe the "bib", Employee E hesitated, then stated, "It's the bib we use to feed residents. That's the one I used on that day, it's brown." When asked again to specifically describe the item he used, Employee B stated again, "It's the brown bib we always use to feed that residents." Employee E was unable to describe a smoking apron.

The surveyor confirmed with the Director of Nursing (Employee A) that the brown clothing protectors on the unit were used for every resident, and that they were not smoking aprons. The facility staff was not able to show the surveyor Resident #1's smoking apron. The DON stated that Resident #1 had a gray smoking apron that had been discarded. The manufacturer's instructions for the brown clothing protector read, "Adult Clothing Protector. Made of heavy domestic terry cloth. 50/50 cotton polyester blend." The clothing protector was not fire

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F 689	Continued From page 17 retardant. Employee B's third statement was submitted via email at the request of the Facility Administrator (Employee C), who was not present in the facility during the survey. The third statement was dated 2/14/19. It read, "On 2/5/19 at around 8:30 pm, I took (Resident #1) of room 170 out in the courtyard so he can have his routine smoke of cigarettes. As usual I put on his smoking apron over him first as I stand and watch. After he finished the first which I gave, the half was trashed into the cigarette (ashtray) and so for the second one too. As always sure that the apron and blankets were taken off him before taking him into his room and put him in his bed and get him clean. I have been working with him for three years and am very conversant with smoking routine and the facility's policy with regards that. On 2/13/19, I received a call from somebody working for the State board and wanted to ask me some questions about the fire accident that took placed on 2/5/19 whilst I was working at Dogwood evening shift. I was asked specifically about the type and color apron I used on [Resident # 1] when I took him out to smoke on the above mentioned date, and my reply was, his smoking apron that he usually use for smoking, was not sure about the color." On 2/13/19 a review was conducted of Resident #1's clinical record, revealing a 4 year old Activities care plan dated 7/8/15. It read, "Often buys cigarettes, alcohol and lighters when on outings and refuses to allow the activity aide to hold items. He hides lighters and cigarettes in his	F 689		

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F 689	Continued From page 18 gloves and becomes aggressive when facility staff request to lock them up for his safety." Resident #1's care plan did not address smoking safety again until after the fire in his bed occurred on 2/5/19. The current care plan read, "Resident brought some ashes to the room and burned some parts of his bed. Monitoring and searches for cigarettes and lighter. Verbal reminders. One on one sitter provided." According to the progress notes, Resident #1 had one on one supervision until 2/8/19. There was no documentation in the progress notes that the one on one supervision had been discontinued. The care plan did not document the discontinuance of one on one supervision. Prior to the fire, Resident # 1 had the following signed physician's orders, "Resident may smoke with staff 2 times in morning and 2 times in the evening." Resident #1's clinical record contained only one Safe Smoking Needs Assessment dated 1/3/19. It read, "Apply Smoking Apron". The facility Smoking Policy, dated 10/3/17 read, "Residents will not be permitted to smoke without the direct supervision of a responsible staff member or volunteer. Direct supervision must be provided throughout the entire smoking period. All residents who smoke will be assessed upon admission, quarterly, and PRN (as needed) as conditions warrants for safety equipment needs. Examples of equipment include smoking aprons and assistive devices. On 2/13/19 at 3:45 P.M. the Director of Nursing was informed of the findings.	F 689		

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