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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 04/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(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 complaint survey was conducted 4/9/19. Two complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 65 certified bed facility was 58 at the time of the survey. The survey sample consisted of ten (10) current Resident reviews (Residents 1 through 10) and two unsampled residents (Resident #1 and #2).	F 000	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, the facility staff failed to follow professional standards of practice for obtaining physician's orders for 1 of 10 residents (Resident #1) prior to use. The facility staff failed to obtain physician's orders for oxygen prior to the use of oxygen. This affected 1 of 10 residents (Resident #1). The findings included: The facility staff failed to ensure there was a physician's order for oxygen prior to the use of oxygen for Resident #1.	F 658		

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

Interim FD — 6.12.19

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 658	Continued From page 1 The clinical record of Resident #1 was reviewed 4/9/19. Resident #1 was admitted to the facility 12/13/18 and readmitted 4/4/19 with diagnoses that included but not limited to chronic obstructive pulmonary disease with exacerbation, tobacco use, epilepsy, atherosclerotic heart disease, dyspnea, muscle weakness, difficulty in walking, unsteadiness on feet, mild cognitive impairment, dysarthria and anarthria, hypertension, angina pectoris, circulatory system disorder, acute bronchitis, pain in right shoulder, and chest pain. Resident #1's 5-day minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/29/19 assessed the resident with a BIMS (brief interview for mental status) Summary Score as 14/15. Resident #1 had no signs or symptoms of delirium, psychosis, or behaviors that affected others. Resident #1's current comprehensive care plan initiated 4/2/19 identified that the resident was at risk for injury of self and others r/t (related to) going out to smoke with oxygen. Interventions: oxygen to be removed prior to smoking, staff will educate Resident #1 r/t no smoking with oxygen and staff will monitor all smoking times. Resident #1's smoking evaluation completed 12/18/18, 1/10/19, and 3/18/19 assessed the resident independent smoking was allowed. With each of these evaluations, Resident #1 was not on oxygen. The smoking evaluation completed 3/24/19 at 14:00 (2:00 p.m.) assessed that the resident did not use oxygen and independent smoking was allowed. A notation was made on the 3/24/19 evaluation that the resident had history of smoking in non-designated areas. The	F 658	Resident #1 no longer resides in the facility. All residents of the facility have the potential to be affected. The Director of Nurses (DON)/designee conducted an audit on 6/11/19 audit of all current residents to identify the use of oxygen to ensure corresponding orders and care plans are in place with corrective action upon discovery. All Staff were re-educated to ensure oxygen orders and corresponding care plans are put in to place for any residents placed on oxygen prior to or on 6/14/19 by the DON/designee. The re-education will include a posttest to validate understanding. New Hires, including agency staff, will be provided education and posttests during orientation by the DON/designee. The DON/Designee will audit all oxygen in use, oxygen care plans, oxygen orders are in place. Audits will be conducted daily times 4 weeks, including weekends, then weekly thereafter.	June 14, 2019

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F 658	Continued From page 2 smoking evaluation was incorrect as Resident #1 had used oxygen upon his discharge from the hospital on 3/24/19. The administrator stated when Resident #1 was discharged from the hospital, there were no orders for the resident to have oxygen but the resident returned with oxygen in use. Resident #1 was smoking on 3/25/19 with oxygen and the tubing ignited and the resident was sent to the emergency room with burns to his face and nares. The smoking evaluation completed on 3/24/19 was based on Resident #1 without oxygen. The administrator stated when Resident #1 returned from the ER visit on 3/25/19, the resident's smoking was reassessed. The surveyor requested the facility policy for oxygen administration from the director of nursing on 4/9/19 at 4:00 p.m. The policy titled "Oxygen: Nasal Cannula Effective date: 01/01/04 Revision Date: 02/01/19" read in part: "1. Verify order." No further information was provided prior to the exit conference on 4/9/19.	F 658	Trends identified will be reported by DON/designee monthly to the Quality Improvement Committee (QIC) for any additional follow up and/or in-servicing until the issue is resolved and randomly thereafter as determined by the QIC committee.	
F 689 SS=G	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.	F 689	Resident #1 no longer resides in the facility. Resident #8 no longer resides in the facility. The Director of Nurses (DON)/designee re-evaluated the smoking policy and procedures in place and determined the policies were not being followed as written.	

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F 689	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, the facility staff failed to ensure a hazard free environment for 2 of 10 residents (Residents #1 and #8). After implementation of a correction plan, the provider's environment continued to not be hazzard free due to the observation that Resident #8 was observed smoking unsupervised and had obtained a cigarrette lighter. The findings included: The facility staff failed to ensure a hazard free of environment for residents that smoke. As a result, Resident #1 received second-degree burns on the face and nares due to the lack of staff supervision and monitoring of those residents who smoke and use oxygen. Resident #1 was smoking on the front porch independently on 3/25/19. The resident failed to remove his oxygen tubing before the cigarette was lit. Resident #1 lit the cigarette, the oxygen tubing ignited and the resident suffered burns to his face and nares. The facility had incorrectly assessed the resident for smoking when the resident returned from the hospital on 3/24/19, administered oxygen without a physician order and did not monitor/supervise residents who are smokers. The clinical record of Resident #1 was reviewed 4/9/19. Resident #1 was admitted to the facility 12/13/18 and readmitted 4/4/19 with diagnoses that included but not limited to chronic obstructive pulmonary disease with exacerbation, tobacco	F 689	All residents of the facility have the potential to be affected. The DON/designee conducted an audit of all smoking assessments from 6/11/19 to present to ensure residents smoking assessments and care plans were accurate and that any special needs of the smokers were being identified with corrective action upon discovery. All residents who smoke were re-educated on 6/11/19 by the DON/Designee of the Smoking policy to include the nonadherence to the policy may result in revoking privileges and/ or initiating of a discharge plan. Signs were implemented on 6/11/19 asking families and visitors to not give residents smoking materials, for the safety of our residents it has to be turned in to the nursing desk for scheduled smoking times. Signage was put in place on or about 6/11/19 that no oxygen is to be present during scheduled smoking times in the designated smoking areas.	

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F 689	Continued From page 4 use, epilepsy, atherosclerotic heart disease, dyspnea, muscle weakness, difficulty in walking, unsteadiness on feet, mild cognitive impairment, dysarthria and anarthria, hypertension, angina pectoris, circulatory system disorder, acute bronchitis, pain in right shoulder, and chest pain. Resident #1's 5-day minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/29/19 assessed the resident with a BIMS (brief interview for mental status) Summary Score as 14/15. Resident #1 had no signs or symptoms of delirium, psychosis, or behaviors that affected others. Resident #1's current comprehensive care plan initiated 4/2/19 identified that the resident was at risk for injury of self and others r/t (related to) going out to smoke with oxygen. Interventions: oxygen to be removed prior to smoking, staff will educate Resident #1 r/t no smoking with oxygen and staff will monitor all smoking times. An additional focus area created 12/17/18 and revised on 3/26/19 read that "Patient may smoke with supervision at designated smoking times. Resident had a smoking related injury on 3/25 while smoking independently with oxygen on." These interventions were created on 12/17/18: Educate patient/health care decision maker on the facility's smoking policy, inform of and reinforce smoking restriction, inform and remind patient of location of smoking areas and times, reassess patients ability to smoke with supervision with any change in condition. These interventions were initiated 3/26/19: Supervise patient with smoking in accordance with assessed needs, ensure there is no oxygen use in smoking area (s), and monitor patients	F 689	All Staff will be-educated of the smoking policy and procedure prior to or on 6/14/19 by the DON/designee to ensure residents are appropriately evaluated for proper smoking assessments and that the status of smoking determination of being independent, supervised or not permitted to smoke has been determined by the IDT team and care planned. All Staff will be re-educated by the DON/designee to assist independent smokers who do not require supervision but have been assessed and care planned as having special care needs such as removal of oxygen when they are signing out to exit the facility for their scheduled smoking time. The re-education will include a posttest to validate understanding. New Hires, including agency staff, will be provided education and posttests during orientation by the DON/designee. The DON/Designee will audit all smoking assessments and corresponding care plans including upon admission, readmission, and with significant change in condition to ensure that residents status of smoking determination are identified properly according to his/her smoking assessment needs. Audits will be conducted daily times 4 weeks, including weekends, then weekly thereafter.	June 14, 2019

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F 689	Continued From page 5 compliance to smoking policy. The administrator accompanied the surveyor to the front porch where Resident #1 was observed sitting on 4/9/19 at 9:29 a.m. waiting to smoke. Resident #1 was alert. The resident was not using oxygen at the time of the observation. A second resident identified as Resident #8 was observed with a package of cigarettes (Eagle 120's) tucked under the edge of his left shorts and was already smoking a cigarette. There was no staff supervising the smoking of Resident #8. The surveyor asked Resident #8 where the cigarettes came from and Resident #8 responded, "A friend gave them to me. I got them about 20 minutes ago from a friend." Resident #8 was also observed with a cigarette lighter and again he was asked where he got the lighter. Resident #8 stated, "My lighters kept disappearing. I don't have any more." Resident #8 stated he got the lighter from another resident but stated, "I ain't divulging who gave it to me. I plead the fifth. I'm going home in 2 hours." The administrator stated to the surveyor "To our knowledge, we thought all of the residents had turned in their cigarettes and lighters." The administrator stated the staff confiscated cigarettes, locked them up, and the staff have followed the smoking policy. "What do you do?" The administrator stated it was like the honor system. "If Resident #8 wasn't discharged today, we would be giving him a discharge notice. Resident #8 had been assessed for smoking on 3/26/19, was assessed to need supervised smoking with a notation that read "Supervision for smoking during designated smoking timers per Westwood smoking policy" and had signed the smoking policy. The smoking policy per the	F 689	Interdisciplinary Team Member will audit residents during smoking activities 5 x week for four weeks then weekly thereafter to ensure that the smoking policy is being followed. Interdisciplinary Team Member will audit to ensure that residents do not have smoking materials in their possession outside of the smoking area/policy 5 X week for four weeks then weekly thereafter. These audits will include weekends and off shifts. Trends identified will be reported by DON/designee monthly to the Quality Improvement Committee (QIC) for any additional follow up and/or in-servicing until the issue is resolved and randomly thereafter as determined by the QIC committee.	

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F 689	Continued From page 6 administrator did not go into effect until 3/25/19. Resident #8 was admitted to the facility 3/20/19 with diagnoses, that included but not limited to coronary artery disease, hypertension, sepsis, diabetes mellitus, anxiety, depression, schizophrenia, and manic depression. Resident #8's smoking evaluation dated 3/26/19 read "2. Supervised smoking is required" and the smoking policy had been signed. Resident #8 did not use oxygen. The clinical record revealed on 3/25/19, Resident #1 was smoking unsupervised on the front porch. The resident had been ordered oxygen when discharged from the hospital on 3/24/19. Resident #1 stated he forgot to remove the oxygen before he smoked because he wasn't use to using oxygen. There were no other residents smoking with Resident #1 at the time of the incident or staff supervision. Resident #1 was sent to the emergency room on 3/25/19 after the tubing ignited and the resident was burned. R.N. #1 stated that Resident #1 was non-compliant with smoking. R.N. #1 stated Resident #1 would remind Resident #7 or help that resident remove his oxygen when they would smoke. That was before Resident #1 was ordered oxygen. R.N. #1 stated Resident #1 was not on oxygen until 3/24/19 and he didn't remember he had it on. The tank was set on 4 liters. The Emergency Department Physician Documentation read, "The patient presents with a burn as a result of OXYGEN, at a nursing home or assisted living facility, is located on the nose and left cheek. Onset: The symptoms/episodes began/occurred just prior to arrival. Burn type	F 689	This page was intentionally left blank.	

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F 689	Continued From page 7 and severity: 1st degree: of the nose and left cheek, 2nd degree: of the nose and left cheek. Associated signs and symptoms: Pertinent positives: confusion, soot at nares. Pertinent negatives: abdominal pain, chest pain, diaphoresis, hearing loss, increased lacrimation, nausea, neck pain, numbness, increased oral secretions, palpitations, singed hair at nares, shortness of breath, vision changes, vomiting. The patient suffered an inhalation injury, CIGARETTE SMOKE (OXYGEN EXPLODED). The patient had no loss of consciousness. The EMS (emergency medical services) care prior to arrival includes: none. 03/25 19:18 (7:18 p.m.) Constitutional: Negative for fever Cardiovascular: Negative for chest pain Skin: Positive for burn, of the nose and left cheek, negative for. All other systems are negative, except as documented in HPI (history of present illness). Constitutional: The patient appears alert, awake, well developed, afebrile Head/face: Noted is erythema, that is moderate, of the nose and left cheek, 2nd degree burn noted Eyes: Exam is negative for acute changes ENT (ears, nose, and throat): External ear (s): are unremarkable, Nose: External nose: no obvious, acute abnormality, nasal mucosa: dry, soot noted to bilateral nostrils, Turbinates are moist and non-edematous, Turbinates: are normal. Mouth: Lips: normal, Oral mucosa: pink and intact, moist, Gums: normal with healthy appearance, Tongue: is normal, Posterior pharynx: Airway: normal, Uvula: midline, edematous, erythema, swelling, that is mild, erythema, that is mild, exudate, is not appreciated, peritonsillar mass, is not	F 689	This page was intentionally left blank.	

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F 689	Continued From page 8 appreciated, no soot or black eschar noted to pharynx. Neck: Exam negative for Respiratory: Exam negative for acute changes Cardiovascular: exam negative for acute changes Skin: Injury, burn (s), and is located on the nose and left cheek Neuro: Exam negative for changes 03/25 19:31 (7:31 p.m.) Other consultation: Cabell Huntington burn unit, do not intubate unless necessary, may apply bacitracin ointment to burn area and inside nostril four times a day, follow-up in nursing home. 03/25 21:17 (9:17 p.m.) Differential diagnosis: 1st degree burns, 2nd degree burns, inhalation injury Disposition: 3/25/19 21:49 (9:49 p.m.) Discharged to nursing home. Impression: Burn of 1st degree of head, face, and neck, unspecified site, initial encounter, Burn of second degree of head, face, and neck, unspecified site, initial encounter. " Condition is stable " Discharge Instructions: Burn care, Easy-to Read, Second-Degree Burn " Medication Reconciliation Form form " Follow up: Private Physician: When: 2-3 days; Reason: Recheck today's complaints, Continuance of care. " Problem is new " Symptoms are unchanged Resident #1 returned to the nursing facility 3/25/19 with orders for Prednisone and Bacitracin ointment four times a day topically to burns. Resident #1's smoking evaluation completed 12/18/18, 1/10/19, and 3/18/19 assessed the	F 689	This page was intentionally left blank.	

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F 689	Continued From page 9 resident independent smoking was allowed. With each of these evaluations, Resident #1 was not on oxygen. The smoking evaluation completed 3/24/19 at 14:00 (2:00 p.m.) assessed that the resident did not use oxygen and independent smoking was allowed. A notation was made on the 3/24/19 evaluation that the resident had history of smoking in non-designated areas. The smoking evaluation was incorrect as Resident #1 had used oxygen upon his discharge from the hospital on 3/24/19. The administrator stated when Resident #1 was discharged from the hospital, there were no orders for the resident to have oxygen. The smoking evaluation completed on 3/24/19 was based on Resident #1 without oxygen. The administrator stated when Resident #1 returned from the ER visit on 3/25/19, the resident's smoking was reassessed. The administrator stated up until 3/25/19, residents who were assessed to be independent in smoking were not supervised but that changed on 3/25/19 with Resident #1's smoking incident. The surveyor reviewed the Smoking Policy on 4/9/19 effective date 06/01/96, review date 06/01/17 and revision date 06/15/17. The policy read in part, "Genesis Healthcare recognizes the myriad of health risks associated with tobacco use, both for the smokers and for those exposed to secondhand smoke. We strongly advocate for a smoke-free policy across our company. At the same time, we recognize that smoking is prevalent among certain patient populations and geographics that we serve. For Centers that allow smoking, smoking (including the use of electronic cigarettes) will be permitted in designated areas only. Patients will	F 689	This page was intentionally left blank.	

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F 689	Continued From page 10 be assessed on admission, quarterly and with change in condition for the ability to smoke safely and if necessary, will be supervised. Smoking is defined as "The inhalation of smoke from burning tobacco or any other substance encased in cigarettes, pipes, and cigars as well as any type of smokeless tobacco products including, but not limited to electronic cigarettes." Supervised smoking is defined as "The observer must be in the direct area of the smoke, within eye contact, and able to respond to emergency situations." PURPOSE: To provide guidelines for smoke-free Centers/campuses. To ensure that patients who choose to smoke will do so safely. To ensure that patients who choose not to smoke are not exposed to smoke. PROCESS 2. For Centers that allow smoking: 2.1 Smoking (including electronic cigarettes) will only be allowed in designated areas. 2.1.1. An area designated as a smoking area will be environmentally separate from all patient care areas (outdoors or a smoking lounge), will be well ventilated, and if outdoors, will protect patients from weather conditions. 2.1.2. A primary gathering place for patients will not be designated as a smoking area so that non-smokers are not subjected to "secondhand" smoke. 2.1.3. Oxygen use is prohibited in smoking areas. 2.1.4. Ashtrays made of non-combustible materials and safe design, and metal containers with self-closing covers into which ashtrays can be emptied, shall be provided in all designated smoking areas as well as at all entrances.	F 689	This page was intentionally left blank.	

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F 689	Continued From page 11 2.1.5. Portable fire extinguishers will be available in the Center. 2.2 The admissions designee will explain the Center's smoking policy to the patients and their families, and inform them that patients will be assessed to determine if supervision is required. 2.3 The admitting nurse will perform a Smoking Evaluation on each patient who chooses to smoke. 2.3.1. Patients will be re-evaluated quarterly and with a change in condition. 2.4 The patient will be allowed to smoke only with direct supervision until the interdisciplinary team has evaluated him/her. 2.5 A patient's smoking status-independent, supervised, or not permitted to smoke-will be documented in the care plan. 2.5.1. The care plan will be updated as necessary. 2.6 Smoking supplies (including, but not limited to, tobacco, matches, lighter, lighter fluid, etc.) will be labeled with the patient's name, room number, and bed number, maintained by staff, and stored in a suitable cabinet kept at the nursing station. 2.6.1. If the patient is cognitively and physically able to secure all smoking materials, the Center may allow him/her to maintain his/her own tobacco or electronic cigarette products in a locked compartment. 2.6.2 Patients will not be allowed to maintain their own lighter, lighter fluid, or matches. 2.7 Center leadership will consider special circumstances on an individual basis (the need for a smoking apron and/or flame retardant clothing). 3. It may be necessary to counsel patients or responsible parties who violate the smoking policy. 4. If there is a "willful" disregard for safety to other	F 689	This page was intentionally left blank.	

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F 689	Continued From page 12 or the Center is jeopardized by a patient's disregard for the smoking policy, termination of smoking privileges or initiation of a discharge plan may occur. 4.1 Such action will be documented in the medical record." The administrator stated the facility reported the smoking incident as an "unusual occurrence to the Office of Licensure and Certification." The administrator, unit manager registered nurse #1, and the unit manager registered nurse #2 stated the facility reassessed all smokers, reviewed all orders for oxygen, educated staff, educated residents, sent letters to the responsible parties, implemented a supervised smoking schedule, and audited smoking assessments/oxygen orders. The administrator, the unit manager registered nurse #1 and the unit manager registered nurse #2 reviewed the facility "ADHOC QAPI Plan for Smoking Incident" on 4/9/19 with the surveyor. The five (5) points of their plan of correction were reviewed. 1). Facility failed to protect resident from accidents/hazards related to smoking with oxygen on. Facility staff failed to assess resident with change in condition (addition of oxygen) to ensure safe smoking. Facility staff failed to follow policy regarding Smoking. Facility failed to follow standards of practice, by administering oxygen without an order. Facility staff failed to protect resident from neglect as a result of all of the above. Which led to Resident #1 having oxygen ignite while smoking, resulting in 2nd and 3rd degree burns.	F 689	This page was intentionally left blank.	

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F 689	Continued From page 13 2) All residents with oxygen and who smoke are at risk related to this deficient practice. 100% audit was completed of all current residents that smoke (5 residents) to determine their safety. 100% audit of all residents receiving oxygen was completed to ensure that they have an active physician's order and to determine if they are smokers. 3) ¢ Nursing staff to be educated on how and when to complete a Smoking Assessment, to include with significant changes such as addition of oxygen. ¢ Nursing staff to be educated on procedure for administering oxygen only with physician's order in place. ¢ Facility staff re-educated on Abuse/Neglect Prevention to include monitoring for safety, prevention of accidents. ¢ Current residents who smoke were re-educated on the Smoking Policy to include non-adherence to the policy may result in revoking smoking privileges, initiating of a discharge plan. ¢ Facility has implemented a supervised smoking schedule. 4) ¢ Facility administration will monitor smoking residents for safety 2x daily, 7 days per week for 3 months, then randomly thereafter to ensure compliance with smoking policy and no oxygen in smoking area. ¢ Nursing leadership will audit smoking assessments weekly for 3 months to ensure that they have been updated with any significant changes. ¢ Nursing leadership will audit new	F 689	This page was intentionally left blank.	

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F 689	Continued From page 14 admissions/readmissions and new orders in the Clinical Monitoring Meeting for oxygen use to ensure that orders are appropriately in place. ¢ All of the above audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5) Date of compliance 3/28/19. The above plan contained a definition of supervised smoking which the facility defined as "the observer must be in the direct area of the smoke, within eye contact, and able to respond to emergency situations." The date of compliance for supervision to be implemented by was identified as 3/28/19: however, the lack of supervision continued and was observed on 4/9/19 by the surveyor and the administrator when Resident #8 was observed with a package of cigarettes (Eagle 120's) tucked under the edge of his left shorts and was already smoking a cigarette. There was no staff supervising the smoking of Resident #8. Resident #8 was also observed with a cigarette lighter. Also, policies and procedures limiting the accessibility of matches and lighters by residents who need supervision when smoking for safety reasons had an effective date 06/01/96, review date 06/01/17 and revision date 06/15/17 and no review date after the 3/25/19 incident with supervison being an issue on 4/9/19. The administrator and unit managers provided the surveyor their credible evidence for the deficient practices identified. 2. The facility provided to the surveyor a 100% audit of all residents at the time of the incident	F 689	This page was intentionally left blank.	

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F 689	Continued From page 15 who were smokers. The list identified eight residents; however, two were in the hospital and one was no longer a smoker. Smoking evaluations were completed on all the current residents who smoke in the facility. The facility provided the surveyor with a list of current residents and the physician's orders for oxygen. 3. In-service education was provided on 3/26/19 for the smoking policy and safe oxygen use, abuse and neglect, recapitulating of physician's orders. The current residents who smoke were re-educated on the Smoking Policy to include non-adherence to the policy. The staff included the smoking policy signed by each of the residents who smoke. A letter was provided to the residents/responsible parties effective 3/27/19 that read, "Westwood Center will only allow smoking/vaping during designated times and in designated areas. The purpose of designated times and areas is to provide opportunities for residents to smoke safely and for non-smokers to enjoy the front porch, without being exposed to second-hand smoke. The designated area will be on the front porch near the window. The designated times will be: 9:30 a.m.-9:45 a.m. 1:30 p.m.-1:45 p.m. 7:00 p.m.-7:15 p.m. 10:00 p.m.-10:15 p.m. A coordinator will obtain all of the smoking supplies, meet the residents on the front porch and distribute smoking materials to residents	F 689	This page was intentionally left blank.	

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F 689	Continued From page 16 choosing to participate. The coordinator will collect all smoking materials to safely store until the next designated time. If you wish to smoke other than designated times listed above, then you will be allowed to take the residents off the property. Please remember to sign the residents out at the nurse's station. If you bring smoking materials to the residents, you must take them to the North Nurse's station where they will be labeled and safely stored for the resident. If you have any questions or concerns, please do not hesitate to contact me at 276-322-5439. Signed by the administrator. The administrator stated the letter was sent out to all residents/responsible parties 3/27/19 and each of the residents who smoke was given a copy. 4. The facility will monitor smoking resident 2 x per day, 7 days a week for 3 months and then randomly thereafter. The surveyor reviewed the daily smoking monitor log that started 3/28/19. The log was correct in the monitoring from 3/28/19 through 4/9/19. The smoking assessments/oxygen audits/new admissions/readmissions audits were reviewed and completed as of 4/9/19. 5. The administrator stated an Adhoc QA meeting was held 3/27/19 with the medical director, the director of nursing, unit manager registered nurse #1, unit manager registered nurse #2, and the social worker. Date of compliance was 3/28/19. The administrator stated he would be the person responsible for implementing the plan of correction.	F 689	This page was intentionally left blank.	

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F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, the facility staff failed to ensure residents who needs respiratory care, including tracheostomy care and tracheal suctioning, are provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This affected 3 of 10 residents (Resident #1, Resident #3, and Resident #5). The findings included: 1. The facility staff failed to ensure there was a physician's order for oxygen prior to the use of oxygen for Resident #1 when the resident returned from the hospital on 3/24/19. The clinical record of Resident #1 was reviewed 4/9/19. Resident #1 was admitted to the facility 12/13/18 and readmitted 4/4/19 with diagnoses that included but not limited to chronic obstructive pulmonary disease with exacerbation, tobacco use, epilepsy, atherosclerotic heart disease, dyspnea, muscle weakness, difficulty in walking,	F 695	1. Resident #1 no longer resides in the facility. All residents of the facility have the potential to be affected. The Director of Nurses (DON)/designee conducted an audit on 6.11.19 audit of all current residents to identify the use of oxygen to ensure corresponding orders and care plans are in place with corrective action upon discovery. All Staff were re-educated to ensure oxygen orders and corresponding care plans are put in to place for any residents placed on oxygen prior to or on 6/14/19 by the DON/designee. The re-education will include a posttest to validate understanding. New Hires, including agency staff, will be provided education and posttests during orientation by the DON/designee. The DON/Designee will audit all oxygen in use, oxygen care plans, oxygen orders are in place. Audits will be conducted daily times 4 weeks, including weekends, then weekly thereafter.	June 14, 201

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F 695	Continued From page 18 unsteadiness on feet, mild cognitive impairment, dysarthria and anarthria, hypertension, angina pectoris, circulatory system disorder, acute bronchitis, pain in right shoulder, and chest pain. Resident #1's 5-day minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/29/19 assessed the resident with a BIMS (brief interview for mental status) Summary Score as 14/15. Resident #1 had no signs or symptoms of delirium, psychosis, or behaviors that affected others. Resident #1's current comprehensive care plan initiated 4/2/19 identified that the resident was at risk for injury of self and others r/t (related to) going out to smoke with oxygen. Interventions: oxygen to be removed prior to smoking, staff will educate Resident #1 r/t no smoking with oxygen and staff will monitor all smoking times. An additional focus area created 12/17/18 and revised on 3/26/19 read that "Patient may smoke with supervision at designated smoking times. Resident had a smoking related injury on 3/25 while smoking independently with oxygen on." These interventions were created on 12/17/18: Educate patient/health care decision maker on the facility's smoking policy, inform of and reinforce smoking restriction, inform and remind patient of location of smoking areas and times, reassess patients ability to smoke with supervision with any change in condition. These interventions were initiated 3/26/19: Supervise patient with smoking in accordance with assessed needs, ensure there is no oxygen use in smoking area (s), and monitor patients compliance to smoking policy. Resident #1 was discharged from the hospital on	F 695	Trends identified will be reported by DON/designee monthly to the Quality Improvement Committee (QIC) for any additional follow up and/or in-servicing until the issue is resolved and randomly thereafter as determined by the QIC committee. 2. Resident #3 no longer resides in the facility. 3. Resident #5 no longer resides in the facility. All residents of the facility have the potential to be affected. The Director of Nurses (DON)/designee conducted an audit on 6/11/19 of all current residents with oxygen orders to ensure appropriate flow rate is being administered to the resident with corrective action upon discovery. All Nursing Staff will be re-educated to ensure oxygen orders are being administered with the appropriate flow rate per the physicians' order of the resident prior to or on 6/14/19 by the DON/designee. The re-education will include a posttest to validate understanding. New hires, including agency staff will be provided education and posttests during orientation by the DON/designee.	

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F 695	Continued From page 19 3/24/19 and returned with oxygen in use. However, there were no physician orders for the oxygen. Resident #1 was smoking on 3/25/19 with oxygen and the tubing ignited and the resident was sent to the emergency room with burns to his face and nares. Resident #1's smoking evaluation completed 12/18/18, 1/10/19, and 3/18/19 assessed the resident independent smoking was allowed. With each of these evaluations, Resident #1 was not on oxygen. The smoking evaluation completed 3/24/19 at 14:00 (2:00 p.m.) assessed that the resident did not use oxygen and independent smoking was allowed. A notation was made on the 3/24/19 evaluation that the resident had history of smoking in non-designated areas. The smoking evaluation was incorrect as Resident #1 had used oxygen upon his discharge from the hospital on 3/24/19. The administrator stated when Resident #1 was discharged from the hospital, there were no orders for the resident to have oxygen. The smoking evaluation completed on 3/24/19 was based on Resident #1 without oxygen. The administrator stated when Resident #1 returned from the ER visit on 3/25/19, the resident's smoking was reassessed. The surveyor requested the facility policy for oxygen administration from the director of nursing on 4/9/19 at 4:00 p.m. The policy titled "Oxygen: Nasal Cannula Effective date: 01/01/04 Revision Date: 02/01/19" read in part: "1. Verify order." No further information was provided prior to the exit conference on 4/9/19.	F 695	The DON/Designee will audit all current residents with oxygen orders to ensure appropriate flow rate is being administered to the resident Audits will be conducted daily times 4 weeks, including weekends, 2X randomly for two weeks then weekly thereafter. Trends identified will be reported by DON/designee monthly to the Quality Improvement Committee (QIC) for any additional follow up and/or in-servicing until the issue is resolved and randomly thereafter as determined by the QIC committee.	

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F 695	Continued From page 20 2. The facility staff failed to ensure Resident #3's receivied the physician ordered amount of oxygen. Resident #3 was admitted to the facility 10/26/15 and readmitted 1/19/16 with diagnoses that included but not limited to carbuncle of the right lower lip and buccal region, pneumonia due to pseudomonas, sepsis, dyspnea, emphysema, chronic obstructive pulmonary disease, with acute exacerbation, asthma, major depressive disorder, insomnia, enlarged prostate, paroxysmal atrial fibrillation, bronchitis and pain. Resident #3's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/8/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15. The surveyor and the unit manager registered nurse #1 toured the residents in the facility who currently had scheduled oxygen orders on 4/9/19 at 2:30 p.m. Resident #3's oxygen concentrator was checked. The April 2019 physician order was for 3 liters per nasal cannula (nc). The oxygen concentrator was on 4 liters/nc. R.N. #1 stated the resident had been known to adjust the amount when he feels short of breath. Resident #3 was not in the room when the observation was made. The surveyor requested the facility policy for oxygen administration from the director of nursing on 4/9/19 at 4:00 p.m. The policy titled "Oxygen: Nasal Cannula Effective date: 01/01/04 Revision Date: 02/01/19" read in part: "1. Verify order."	F 695	This page was intentionally left blank.	

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F 695	Continued From page 21 No further information was provided prior to the exit conference on 4/9/19. 3. The facility staff failed to ensure Resident #5 received oxygen as ordered. Resident #5 was admitted to the facility 3/29/19. The admission minimum data set (MDS) had not yet been completed. Admission diagnosis included chronic obstructive pulmonary disease (COPD). The unit manager registered nurse #1 and the surveyor compared the residents receiving oxygen with the current order on 4/9/19 at 2:30 p.m. There were twenty residents with orders for oxygen continuous and as needed. Resident #5 had orders for oxygen at 3 liters/nasal cannula every night at bedtime. When checked, the oxygen was set at 2 liters. R.N. #1 stated the resident only gets oxygen at bedtime and turned the concentrator off. The April 2019 physician order was for 3 liters per nasal cannula (nc) every night at bedtime. The oxygen concentrator was on 2 liters/nc. The surveyor requested the facility policy for oxygen administration from the director of nursing on 4/9/19 at 4:00 p.m. The policy titled "Oxygen: Nasal Cannula Effective date: 01/01/04 Revision Date: 02/01/19" read in part: "1. Verify order." No further information was provided prior to the	F 695	This page was intentionally left blank.	

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F 695	Continued From page 22 exit conference on 4/9/19.	F 695	This page was intentionally left blank.	