| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 145636 | A. BUILDING _____ B. WING _____ | C 11/30/2011 |

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| **CHARLESTON REHAB & HEALTH CARE CENTER** | **716 EIGHTEENTH STREET CHARLESTON, IL 61920** |

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| F 000 | INITIAL COMMENTS<br><br>Investigation of 11-19-11 Incident (IL55405)<br><br>A partial extended survey was conducted. | F 000 | | |
| F 323 SS=K | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and interview the facility staff failed to remove a liquid oxygen tank, and cannula from R1 prior to allowing R1 to smoke. This resulted in R1's oxygen cannula igniting causing complex facial burns to R1's face, and placing the other residents present (R2, R3 and R4) at risk of injury. R1, R2, R3, and R4 are 4 residents reviewed for smoking safety in the sample of six.<br><br>This failure resulted in an Immediate Jeopardy.<br><br>The facility removed the immediate jeopardy on 11-29-11, but remains out of compliance at a severity level 2. The facility continues to monitor for the effectiveness of staff inservice re-education and revised policy implementation related to smoking safety and oxygen use.<br><br>The findings include: | F 323 | | 11/30/11 |

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

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| F 323 | Continued From page 1<br><br>On 11/10/11 the facility faxed an initial incident report to the State Survey and Certification Agency Regional Office which stated "Resident outside to smoke with oxygen on, cigarette lit causing a flash burn November 19, 2011. Investigation initiated and final report to follow."<br><br>The Admission record shows R1 was admitted to the facility on 11/08/11 for a short stay. Social Service History and Admission note documented that R1 was 64 years old and was admitted from his apartment in the community. Notes document "resident says he needs nursing care and wants to come (to the facility) to get better. Resident has trouble breathing and gets winded easily".<br><br>R1's admitting diagnosis on the November 2011 Physicians Order Sheet was COPDE (chronic obstructive pulmonary disease excacerbation ). R1 had 11/08/11 orders for Physical and Occupational therapy for 30 days. R1 had an admitting physicians order for Oxygen at 2 liters per minute by nasal cannula PRN (as needed).<br><br>R1's Minimum Data Set (MDS) dated 11/21/11 documented R1 was cognitively intact, required limited assistance of one staff for transfers and ambulation, and was independent in wheelchair mobility. The assessment documented goal was resident expected to be discharged to the community and the careplan team had also deemed discharge feasible for R1.<br><br>R1's Nurses notes dated 11/19/11 6:40 pm documents "Nurse on duty notified that (resident) acquired facial burns when outside smoking with O2 (oxygen) tank. On call nurse (E3) instructed | F 323 | | |

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| F 323 | Continued From page 2 | F 323 | | |

nurse to transfer resident to (local hospital) via 911." Notes of 11/19/11 9:00 pm documented R1 was on a ventilator and was being transferred via helicopter. The hospital nurse reported the resident was intubated, and put on ventilator for soot accumulation in naso/oral pharynx, R1 had acquired 2nd and 3rd degree facial burns and 2nd degree burns to right hand. The resident was transferred to a Springfield burn unit.

The local Hospital Emergency Room Report dated 11/19/11 documents R1's past medical history with diagnoses of Chronic Obstructive Pulmonary Disease, Hypertension, Mental Retardation and Schizophrenia. The report documents R1 had burns to mid face and nose area and upper lip with soot noted diffusely to area, broken blisters over nose tip to about three quarters of nose..soot and singed burns to nasal passages...broken blisters to upper lip, pale in appearance and insensitive to touch to entire upper lip consistent with possible full thickness burn..deep swelling in nasal passages". The report documented R1 had a nasopharyngeal scope of the airway by (Z2) ENT (Ear Nose Throat) physician. The report documented there was "some edema about the tracheal level " The residents airway was protected with intubation and the resident was given medication for pain relief and sedation. The clinical impression was "Complex Facial Burns with Suspected Full Thickness Upper Lip Burn. Partial Thickness Burns to the right index, third and fourth finger and left index finger and Suspected Inhalation Injury."

The facility final incident report summary dated 11/23/11 documented "staff member, (E7)

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| F 323 | Continued From page 3<br>escorted resident to smoking area. E7 did not have nurse remove oxygen before exiting facility. Resident attempted to relight cigarette and ash caused flash burn." The report documented the resident was assessed and sent to (local hospital) and then was transferred to a Springfield hospital. The report documented "During interviews it was determined (E7) was aware oxygen was to be removed prior to resident smoking and this did not occur. Resident is alert and oriented."<br><br>Administrator, E1 stated on 11/28/11 at 10:10 am that R1 was still in the Burn Unit of the hospital. E1 confirmed that R1 had gotten burned on 11/19/11 while out in the courtyard smoking. E1 stated that other residents outside at the time of the incident included R2 and R3 who she stated were non interviewable.<br>E1 during the same interview, all of the resident smoking is done outside of the building, and is supervised by staff with a smoking schedule. The residents are taken outside to the outdoor courtyard to smoke. E1 demonstrated that the courtyard was located between the West and Northwest wings of the facility. A side walk from each wing leads to a covered gazebo in the center of of the courtyard approximately 25 feet from the building. The exterior doors to the courtyard on the West and Northwest wings were equipped with a keyed alarmed lock. E1 stated that the staff had to use a key to shut off the alarm and open the door before letting residents outside to smoke.<br><br>A large sign was taped to the door which said "NO OXYGEN BEYOND THIS POINT NURSING MUST REMOVE OXYGEN". On 11-28-11 at 10:20 a.m. E1 stated that this sign had been | F 323 | | |

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posted on both doors after R1's accident.

The Smoking Schedule was posted on the wall by the exterior doors to the courtyard. The schedules listed smoking times every two hours from 6:30 am until 8:30 pm. Laundry staff, Housekeeping staff, Social Services, or Dietary staff were assigned to supervise smoking for all smoke times except 4:00 pm and 8:30 pm when a Certified Nurse Aide (CNA) supervises the smoking. The sign stated "Resident smoking is ONLY permitted during the above designated times. ALL residents must be at the door waiting for staff to assist them outside. Residents are allowed one cigarette per smoke break."

E1 provided E7's written statement dated 11/20/11 (error on date) 6:31 pm which stated "I took (R1, R4, R3, and R2) out to smoke. (R1) was smoking and his oxygen tubes caught on fire because he took a drag off of his cigarette and it just sparked and went up in flames. I tried to get the flames out and off his tubes and then I ...told the closest CNA to go find her (nurse)...At the time he was attempting to relight his own cigarette".

On 11-28-11 at 10:10 a.m. E1 stated that she had interviewed E7 and asked why she had not removed R1's oxygen tank before she took him out to smoke. E1 stated E7 stated that she was aware of the policy (oxygen safety) but was "busy thinking of other things." E1 stated that's why E7's employment was terminated.

Nurse, E3 stated on 11/28/11 at 11:00 am that she was the nurse on call and was notified by Nurse, E10 that R1 had been injured. E3 stated

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| F 323 | Continued From page 5<br>when she arrived at the facility about five minutes later, R1 was at the the nurse's station in his wheelchair with an ice pack on his face and mouth.<br><br>E3 stated she interviewed Laundry staff E7, who was the assigned smoking monitor. E7 kept saying that the nurse had not taken off the oxygen. E3 stated she told E7 "But you were the one who lit the cigarette". E3 said she did confirm that E7 had taken the residents out to the courtyard to smoke, that R1 was wearing the oxygen when E7 took him out to smoke and that E7 had lit R1's cigarette.<br><br>E3 stated the Smoking Protocol was the nurse keeps the cigarettes at the nurse's station. The Nurse hands out the cigarettes when the assigned staff member is ready to take out the resident to smoke. According to E3 the nurse is to remove any oxygen from the resident before the resident is taken out to smoke.<br>E3 stated on 11/29/11 at 11:00 am when she arrived at the facility R1 was inside the facility and the oxygen tank was outside in the courtyard, and the oxygen tubing was all burnt.<br><br>R2 stated on 11/28/11 at 12:15 pm that she was present when R1 had been burned. R2 stated the laundry girl, E7 had taken her, R3, R4 and R1 out to the courtyard, the nurse wasn't at the desk at the time around 6:15 pm. R2 said E7 had the cigarettes and they were all sitting pretty close together around a round metal table in the gazebo. R2 stated she was across the table from R1 and R3 was seated right next to R1. R2 stated E7 had lit our cigarettes, and (R1's) cigarette hadn't lit all the way, he took a drag and | F 323 | | |

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it sparked, and caught the tubing on fire. R1 yelled and started slapping his face. R2 stated " I told (E7) someone needed to get a nurse!" E7 said a CNA got the West Wing nurse and they took the oxygen tank off of him.

On 11/28/11 at 12:45pm R3 stated "He (R1) was lighting up a cigarette when it kind of flared up. He was sitting right next to me. I felt the heat but I didn't get burned." R3 said he saw the blaze and he felt the heat on his wrist and face. R3 stated he has smoked with "that guy" before and "they always took the tank and everything off before but this time they didn't."

On 11/28/11 at 1:30 pm. R4 confirmed he was present when R1 got hurt. R4 stated that R1 had a cigarette and when he lit the cigarette, he got burned. R4 said his face was burned and he's in the hospital. R4 stated that they don't carry their own lighters the escort lights the cigarette.

Nurse, E11 stated on 11/28/11 at 2:00 pm that on 11/19/11 she was the Nurse for the Northwest Wing. E11 stated she had been in a patient room when she was notified by CNA E8 that R1 had been burned while smoking outside with oxygen. E12, the other nurse had already responded and was with R1. E11 said R1's face was blackened from nose to chin, he had a good level of consciousness and was complaining of pain to face and his hand. E11 stated R1's physician had been paged several times with no response and 911 was then called.

E11 stated that she was not present when the residents R1, R2, R3 and R4 were taken out to smoke. E11 had handed R3 and R4 their

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cigarettes, which were locked in her medication cart after supper while they were waiting to go out to smoke. E11 stated she did not give R1 any cigarettes as he was in the hall by his room, not at the desk. E11 stated R1 hand rolls his cigarettes and the machine and tobacco and filters are kept in the unlocked CNA (Certified Nurse Aide) room. E11stated that R1 utilizes a mini portable liquid oxygen tank. If she had been there when the residents were taken out to smoke, she would have removed the whole thing (tank and cannula) from the wheelchair before they went outside.

Nurse, E10 stated on 11/28/11, at 2:10 pm she had been in the dining room on 11/19/11 after supper when CNA E8 had come to her saying there was an emergency, that the oxygen tank hand blown up in R1's face, that the laundry girl had taken residents out to smoke and had not removed the oxygen tank. E10 went out to the courtyard to assess R1. E10 stated R1 was conscious, the staff had turned off the oxygen tank and the cannula was burnt and R1's face was black. E10 stated it was dark outside it was after 6:00 pm. E10 the other nurse then took over and she went inside to call. E10 stated Nurses don't take the residents outside to smoke. If the residents have oxygen the nurse it to take the oxygen tank off before they go outside.
E10 stated on 11/29/11 at 2:30 pm when she saw R1 in the courtyard (on 11/19/11) the staff had asked her what to do with R1's oxygen tank, E10 told them to get it away from him and the chair. E10 didn't recall if the tank was still on the residents chair, E10 stated the oxygen cannula had burnt up and there was a piece of stuck to R1's face.

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| F 323 | Continued From page 8<br><br>CNA, E8 stated on 11/28/11 at 4:15 pm that he had brought R1 back to the North West wing after supper on 11/19/11. E8 said laundry staff takes the residents out to smoke while the CNA's are putting people to bed. E8 stated that E7 had told him what happened, she said that R1 was smoking and there was a poof and the plastic tubing was on fire so she pulled the tubing off of R1. E7 stated he shut the oxygen tank off . E7 stated he grabbed the nurse (E10) and they rushed outside.<br><br>The undated facility "Safe Smoking Policy" outlined conducting a smoking safety risk assessment for residents that smoke, having a Smoking Contract completed by the Social Service Designee and resident and listed rules to follow for smoking. There was no discussion of safety concerns for residents who utilize oxygen that smoke in the policy. Care Plan Coordinator, E4 stated on 11/28/11 at 11:00 am that R1 did not have a smoking assessment or smoking contract completed. R1 only had an Interim Care Plan that only stated "O2 (oxygen) per N/C (nasal cannula), Smokes". E4 stated she didn't include any safety information for removing the oxygen tank before smoking because it was facility policy. At the bottom of the page E4 had written "11/19/11 Sent to ER for eval and tx, will re-eval for safety upon readmit. All inservice on O2 safety."<br><br>The facility "Oxygen Safety General Standards" states "Safety standards for oxygen are designed to ensure the safety of all persons involved in the transport, storage and use of oxygen. Oxygen is a non -flammable gas. In the presence of an | F 323 | | |

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ignition source and a fuel oxygen will vigorously accelerate combustion." The policy states "A. No Smoking: Smoking is prohibited in all areas where oxygen is stored, transported, or used... F. Residents, nursing agency personnel/caregivers and families must be educated regarding the safe use of oxygen. They must be informed of the hazards and all regulations associated with use."

On 11-28-11 the facility Administrator, E1 was notified that an Immediate Jeopardy had been identified. The Immediate Jeopardy began on 11/19/11 when E7 failed to ensure that R1's oxygen was removed before smoking. The surveyor confirmed though interview, observation, and record review that the facility took the following actions to remove the Immediate Jeopardy:

On 11/19/11 Staff member extinguished flames, removed oxygen, moved resident to safety, assessed and sent R1 out for Emergency Medical Treatment.

On 11/19/11 The facility initiated all staff inservice on Oxygen Safety which is on going until all staff are inserviced. Staff are being inserviced prior to starting their scheduled shift.
Signs were posted on doors leading to the designated smoking area to have nurse remove oxygen prior to exiting.

On 11/19/11 1:1 (one to one) education on Oxygen Safety was provided to residents who smoke and are on oxygen.

On 11/21/11 the Quality Assurance Committee initiated Nursing Oxygen Safety monitoring in the

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| F 323 | Continued From page 10<br>facility which was conducted by Administrator E1.<br><br>On 11/29/11 Safe smoking policy was reviewed and revised to include precautions for residents with oxygen. | F 323 | | |
| F9999 | FINAL OBSERVATIONS<br><br>LICENSURE VIOLATION<br><br>300.610a)<br>300.1210b)<br>300.1210d)6)<br>300.3240a)<br><br>Section 300.610 Resident Care Policies<br><br>a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with | F9999 | | |

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each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These regulations are not met, as evidenced by the following:

Based on observation, record review and interview the facility staff failed to remove a liquid oxygen tank, and cannula from R1 prior to allowing R1 to smoke. This resulted in R1's oxygen cannula igniting causing complex facial burns to R1's face, and placing the other residents present (R2, R3 and R4) at risk of injury. R1, R2, R3, and R4 are 4 residents reviewed for smoking safety in the sample of six.

Findings include:

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On 11/10/11 the facility faxed an initial incident report to the State Survey and Certification Agency Regional Office which stated "Resident outside to smoke with oxygen on, cigarette lit causing a flash burn November 19, 2011. Investigation initiated and final report to follow."

The Admission record shows R1 was admitted to the facility on 11/08/11 for a short stay. Social Service History and Admission note documented that R1 was 64 years old and was admitted from his apartment in the community. Notes document "resident says he needs nursing care and wants to come (to the facility) to get better. Resident has trouble breathing and gets winded easily."

R1's admitting diagnosis on the November 2011 Physicians Order Sheet was COPDE (chronic obstructive pulmonary disease excacerbation ). R1 had 11/08/11 orders for Physical and Occupational therapy for 30 days. R1 had an admitting physicians order for Oxygen at 2 liters per minute by nasal cannula PRN (as needed).

R1's assessment dated 11/21/11 documented R1 was cognitively intact, required limited assistance of one staff for transfers and ambulation, and was independent in wheelchair mobility. The assessment documented goal was resident expected to be discharged to the community and the careplan team had also deemed discharge feasible for R1.

R1's Nurses notes dated 11/19/11 6:40 pm document "Nurse on duty notified that (resident) acquired facial burns when outside smoking with O2 (oxygen) tank. On call nurse (E3) instructed nurse to transfer resident to (local hospital) via

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911." Notes of 11/19/11 9:00 pm documented R1 was on a ventilator and was being transferred via helicopter. The hospital nurse reported the resident was intubated, and put on ventilator for soot accumulation in naso/oral pharynx. R1 had acquired 2nd and 3rd degree facial burns and 2nd degree burns to right hand. The resident was transferred to a Springfield burn unit.

The local Hospital Emergency Room Report dated 11/19/11 documents R1's past medical history with diagnoses of Chronic Obstructive Pulmonary Disease, Hypertension, Mental Retardation and Schizophrenia. The report documents R1 had burns to mid face and nose area and upper lip with soot noted diffusely to area, broken blisters over nose tip to about three quarters of nose..soot and singed burns to nasal passages...broken blisters to upper lip, pale in appearance and insensitive to touch to entire upper lip consistent with possible full thickness burn..deep swelling in nasal passages." The report documented R1 had a nasopharyngeal scope of the airway by (Z2) ENT (Ear Nose Throat) physician. The report documented there was "some edema about the tracheal level." The resident's airway was protected with intubation and the resident was given medication for pain relief and sedation. The clinical impression was "Complex Facial Burns with Suspected Full Thickness Upper Lip Burn. Partial Thickness Burns to the right index, third and fourth finger and left index finger and Suspected Inhalation Injury."

The facility final incident report summary dated 11/23/11 documented "staff member, (E7) escorted resident to smoking area. E7 did not

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have nurse remove oxygen before exiting facility. Resident attempted to relight cigarette and ash caused flash burn." The report documented the resident was assessed and sent to (local hospital) and then was transferred to a Springfield hospital. The report documented "During interviews it was determined (E7) was aware oxygen was to be removed prior to resident smoking and this did not occur. Resident is alert and oriented."

Administrator, E1 stated on 11/28/11 at 10:10 am that R1 was still in the Burn Unit of the hospital. E1 confirmed that R1 had gotten burned on 11/19/11 while out in the courtyard smoking. E1 stated that other residents outside at the time of the incident included R2 and R3 who she stated were non-interviewable.

E1 stated during the same interview that all of the resident smoking is done outside of the building, and is supervised by staff with a smoking schedule. The residents are taken outside to the outdoor courtyard to smoke. E1 demonstrated that the courtyard was located between the West and Northwest wings of the facility. A sidewalk from each wing leads to a covered gazebo in the center of of the courtyard approximately 25 feet from the building. The exterior doors to the courtyard on the West and Northwest wings were equipped with a keyed alarmed lock. E1 stated that the staff had to use a key to shut off the alarm and open the door before letting residents outside to smoke.

A large sign was taped to the door which said "NO OXYGEN BEYOND THIS POINT NURSING MUST REMOVE OXYGEN." On 11-28-11 at 10:20 a.m. E1 stated that this sign had been

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posted on both doors after R1's accident.

The Smoking Schedule was posted on the wall by the exterior doors to the courtyard. The schedules listed smoking times every two hours from 6:30 am until 8:30 pm. Laundry staff, Housekeeping staff, Social Services, or Dietary staff were assigned to supervise smoking for all smoke times except 4:00 pm and 8:30 pm when a Certified Nurse Aide (CNA) supervises the smoking. The sign stated "Resident smoking is ONLY permitted during the above designated times. ALL residents must be at the door waiting for staff to assist them outside. Residents are allowed one cigarette per smoke break."

E1 provided E7's written statement dated 11/20/11 (error on date) 6:31 pm which stated "I took (R1, R4, R3, and R2) out to smoke. (R1) was smoking and his oxygen tubes caught on fire because he took a drag off of his cigarette and it just sparked and went up in flames. I tried to get the flames out and off his tubes and then I ...told the closest CNA to go find her (nurse)...At the time he was attempting to relight his own cigarette."

On 11-28-11 at 10:10 a.m. E1 stated that she had interviewed E7 and asked why she had not removed R1's oxygen tank before she took him out to smoke. E1 stated E7 stated that she was aware of the policy (oxygen safety) but was "busy thinking of other things." E1 stated that's why E7's employment was terminated.

Nurse, E3 stated on 11/28/11 at 11:00 am that she was the nurse on call and was notified by Nurse, E10 that R1 had been injured. E3 stated

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when she arrived at the facility about five minutes later, R1 was at the the nurse's station in his wheelchair with an ice pack on his face and mouth.

E3 stated she interviewed Laundry staff E7, who was the assigned smoking monitor. E7 kept saying that the nurse had not taken off the oxygen. E3 stated she told E7 "But you were the one who lit the cigarette." E3 said she did confirm that E7 had taken the residents out to the courtyard to smoke, that R1 was wearing the oxygen when E7 took him out to smoke and that E7 had lit R1's cigarette.

E3 stated the Smoking Protocol was the nurse keeps the cigarettes at the nurse's station. The nurse hands out the cigarettes when the assigned staff member is ready to take out the resident to smoke. According to E3 the nurse is to remove any oxygen from the resident before the resident is taken out to smoke.

E3 stated on 11/29/11 at 11:00 am when she arrived at the facility R1 was inside the facility and the oxygen tank was outside in the courtyard, and the oxygen tubing was all burnt.

R2 stated on 11/28/11 at 12:15 pm that she was present when R1 had been burned. R2 stated the laundry girl, E7 had taken her, R3, R4 and R1 out to the courtyard, and the nurse was not at the desk at the time around 6:15 pm. R2 said E7 had the cigarettes and they were all sitting pretty close together around a round metal table in the gazebo. R2 stated she was across the table from R1 and R3 was seated right next to R1. R2 stated E7 had lit our cigarettes, and (R1's)

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cigarette had not lit all the way. He took a drag and it sparked, and caught the tubing on fire. R1 yelled and started slapping his face. R2 stated "I told (E7) someone needed to get a nurse!" E7 said a CNA got the West Wing nurse and they took the oxygen tank off of him.

On 11/28/11 at 12:45pm R3 stated "He (R1) was lighting up a cigarette when it kind of flared up. He was sitting right next to me. I felt the heat but I didn't get burned." R3 said he saw the blaze and he felt the heat on his wrist and face. R3 stated he has smoked with "that guy" before and "they always took the tank and everything off before but this time they didn't."

On 11/28/11 at 1:30 pm. R4 confirmed he was present when R1 got hurt. R4 stated that R1 had a cigarette and when he lit the cigarette, he got burned. R4 said his face was burned and he is in the hospital. R4 stated that they do not carry their own lighters the escort lights the cigarette.

Nurse, E11 stated on 11/28/11 at 2:00 pm that on 11/19/11 she was the nurse for the Northwest Wing. E11 stated she had been in a patient room when she was notified by CNA E8 that R1 had been burned while smoking outside with oxygen. E12, the other nurse had already responded and was with R1. E11 said R1's face was blackened from nose to chin, he had a good level of consciousness and was complaining of pain to face and his hand. E11 stated R1's physician had been paged several times with no response and 911 was then called.

E11 stated that she was not present when the residents R1, R2, R3 and R4 were taken out to

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smoke. E11 had handed R3 and R4 their cigarettes, which were locked in her medication cart after supper while they were waiting to go out to smoke. E11 stated she did not give R1 any cigarettes as he was in the hall by his room, not at the desk. E11 stated R1 hand rolls his cigarettes and the machine and tobacco and filters are kept in the unlocked CNA (Certified Nurse Aide) room. E11stated that R1 utilizes a mini portable liquid oxygen tank. If she had been there when the residents were taken out to smoke, she would have removed the whole thing (tank and cannula) from the wheelchair before they went outside.

Nurse, E10 stated on 11/28/11 at 2:10 pm she had been in the dining room on 11/19/11 after supper when CNA E8 had come to her saying there was an emergency, that the oxygen tank hand blown up in R1's face, that the laundry girl had taken residents out to smoke and had not removed the oxygen tank. E10 went out to the courtyard to assess R1. E10 stated R1 was conscious, the staff had turned off the oxygen tank and the cannula was burnt and R1's face was black. E10 stated it was dark outside, it was after 6:00 pm. E10 the other nurse then took over and she went inside to call. E10 stated nurses do not take the residents outside to smoke. If the residents have oxygen the nurse it to take the oxygen tank off before they go outside.

E10 stated on 11/29/11 at 2:30 pm when she saw R1 in the courtyard (on 11/19/11) the staff had asked her what to do with R1's oxygen tank. E10 told them to get it away from him and the chair. E10 did not recall if the tank was still on the resident's chair. E10 stated the oxygen cannula

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| F9999 | Continued From page 19<br>had burnt up and there was a piece stuck to R1's face.<br><br>CNA, E8 stated on 11/28/11 at 4:15 pm that he had brought R1 back to the North West wing after supper on 11/19/11. E8 said laundry staff takes the residents out to smoke while the CNA's are putting people to bed. E8 stated that E7 had told him what happened. She said that R1 was smoking and there was a poof and the plastic tubing was on fire so she pulled the tubing off of R1. E7 stated he shut the oxygen tank off. E7 stated he grabbed the nurse (E10) and they rushed outside.<br><br>The undated facility "Safe Smoking Policy" outlined conducting a smoking safety risk assessment for residents that smoke, having a Smoking Contract completed by the Social Service Designee and resident, and listed rules to follow for smoking. There was no discussion of safety concerns for residents who utilize oxygen that smoke in the policy. Care Plan Coordinator, E4 stated on 11/28/11 at 11:00 am that R1 did not have a smoking assessment or smoking contract completed. R1 only had an Interim Care Plan that only stated "O2 (oxygen) per N/C (nasal cannula), Smokes." E4 stated she did not include any safety information for removing the oxygen tank before smoking because it was facility policy. At the bottom of the page E4 had written "11/19/11 Sent to ER for eval and tx, will re-eval for safety upon readmit. All inservice on O2 safety."<br><br>The facility "Oxygen Safety General Standards" states "Safety standards for oxygen are designed to ensure the safety of all persons involved in the | F9999 | | |

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| F9999 | Continued From page 20<br>transport, storage and use of oxygen. Oxygen is a non -flammable gas. In the presence of an ignition source and a fuel oxygen will vigorously accelerate combustion." The policy states "A. No Smoking: Smoking is prohibited in all areas where oxygen is stored, transported, or used... F. Residents, nursing agency personnel/caregivers and families must be educated regarding the safe use of oxygen. They must be informed of the hazards and all regulations associated with use."<br><br>(A) | F9999 | | |