STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. BUILDING _____ B. WING _____	C 03/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

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F 000	INITIAL COMMENTS	F 000		

Complaint Investigations (CI) MS #17579 and CI MS #17584 were conducted by the State Agency (SA) on 03-05-2021 through 03-11-2021. During the survey, the facility was found to not be in compliance with regulations implemented by the Centers for Medicare and Medicaid (CMS). CI MS #17584 was substantiated, related to Quality of Care and treatment, with deficiencies cited at F689, F835, and F926.

The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 02-21-2021 when the facility administration failed to ensure resident's safety by supervising the smoking area during resident smoke times, completing accurate smoking assessments for each resident's level of safety while smoking, and adhering to the safety recommendations, ensuring residents were not smoking in the presence of oxygen supplies, and having knowledge residents had access to lighters and combustible smoking paraphernalia in their rooms without securing them.

The facility's failure to follow CMS guidelines for smoking safety resulted in one (1) resident lighting a cigarette while in his bed, wearing oxygen, and suffering third degree burns to his right shoulder, right chest, and right upper back, along with inhalation burns and later succumbing to his injuries while in the hospital. These actions also resulted in the evacuation and relocation of an entire unit of residents, with loss of personal property and water damage that claimed 32 beds in the facility. These actions placed all resident at risk, and in a situation that was likely to cause serious harm, injury, impairment, and further

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

Electronically Signed | 04/09/2021

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F 000	Continued From page 1	F 000		

death.

On 03-08-2021, at 2:00 PM, the SA notified the Administrator of the Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) and the IJ template was provided to the Administrator.

The IJ and SQC existed at:

42 CFR(s): §483.25(d)(1)(2) - Accidents/Supervision (F689) - Scope and Severity - "L"

IJ existed at:

42 CFR(s): §483.70 -Administration (F835) - Scope and Severity - "L"
42 CFR §483.90(i)(5) - Smoking Policies (F926) - Scope and Severity - "L"

The facility submitted an acceptable Removal Plan on 03-09-2021, at 4:40 PM, in which the facility alleged all corrective actions to remove the IJ were completed on 03-09-2021 and the IJ was removed on 03-10-2021.

The SA validated the Removal Plan on 03-11-2021, and determined the IJ was removed on 03-10-2021, prior to exit. Therefore, the scope and severity for 42 CFR(s): §483.25(d)(1)(2) - Accidents/Supervision (F689), 42 CFR(s): §483.70 -Administration (F835) and 42 CFR §483.90(i)(5) - Smoking Policies (F926) were lowered from an "L" to an "F", while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory compliance.

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F 000	Continued From page 2 CI MS #17579 was substantiated regarding Quality of Care/Treatment and Physical Environment, with deficiencies cited at F686, F695, and F921. The census at the time of the survey was 133, and the facility held a license for 180 beds.	F 000		
F 689 SS=L	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 observations, record reviews, resident interviews, staff interviews, and facility policy review, the facility failed to ensure resident's safety by not supervising the smoking area during resident smoke times, failing to ensuring residents were not smoking in the presence of oxygen, not administering timely smoking safety assessments, not abiding by the assessments recommendations, and administration having knowledge of residents with lighters and combustible smoking paraphernalia in their rooms and failing to secure them for 20 of 20 smokers out of a total of 133 residents, with a sample of seven (7), Residents #1, #2, #3, #4, #5, #6 and #7. The facility's failure to provide supervision for the smoking process placed residents at risk, and in	F 689	Preparation and submission of the plan of correction by Yazoo City Rehabilitation and Healthcare Center does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirement of state and federal law. 1. On 03/8/21 at 2:20PM State Agency (SA) notified facility department heads to include Administrator of Immediate Jeopardy (IJ) with substandard quality of	4/9/21

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F 689	Continued From page 3 a situation, which caused serious injury and death for one (1) resident, Resident #1, and was likely to cause serious injury, harm, impairment, or death for others. The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 02-21-2021, when the facility's failure to provide supervision of residents while smoking, failure to ensure they were not smoking in the presence of oxygen (O2) or combustible chemicals, and failure to ensure the removal of lighters and combustible materials from residents rooms resulted in a resident smoking in his bed, with his oxygen on, causing a fire in the facility that gave him third degree burns to his right shoulder, right front chest, and right upper back which required surgical removal of devitalized skin and adipose layers, as well as extensive skin grafts. He also suffered from inhalation burns, which later contributed to his demise. The facility also had to relocate 23 residents to alternate beds within the facility who incurred loss of personal property, with a loss of 32 beds within the facility to water damage. On 03-08-2021 at 2:00 PM, the State Agency (SA) informed the Nursing Home Administrator (NHA) of the Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC). The IJ and SQC existed at: 42 CFR(s): §483.25(d)(1)(2) - Accidents/Supervision (F689) - Scope and Severity - "L". The facility submitted a credible Removal Plan on 03-09-2021 at 4:40 PM, in which the facility	F 689	care related to accidents/supervision, Administration and Smoking policies. Facility failed to provide adequate supervision ensuring Residents were abiding by established smoking rules/policy regarding smoking materials resulting in Resident #1 obtaining lighter and lighting a cigarette lying in bed with oxygen causing fire in the facility that resulted in burns to right shoulder, chest and back. Resident #2 failing to abide by facility policy with possession of electronic cigarettes. On 2/21/21 at 3:06 pm Receptionist #1 called 911 while facility alarm was sounding. Alarm company also contacted fire department. On 02/21/21 at 3:12pm Fire department dispatched EnRoute to facility and arrived at 3:14pm. Sprinkler system was actively spraying water causing excessive smoke. Sprinkler system extinguished the fire prior to arrival of Fire Department. On 02/21/21 at 3:15 pm LPN #2 called 911 requested ambulance. On 02/21/21 at 3: 12PM Resident #1 was assessed by RN (Registered Nurse) #1. Resident #1 had burns to right front and rear shoulder, Right Scapula, and Right side of chest. Ambulance Service arrived at facility at 4:06PM and begin further evaluation of Resident and transferred to burn center. The facility has no outside legal representative for Resident #1. Resident #1 is his own responsible party. The facility initiated an investigation. On 02/21/21 at 3:15 PM Remaining twenty-three (23) Residents in fire door area begin being escorted to outside parking lot to account for and ensure	

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F 689	Continued From page 4	F 689		

alleged all corrective actions to remove the IJ were completed and the IJ removed as of 03-10-2021.

The SA validated the Removal Plan on 03-11-2021 and determined the IJ was removed prior to exit. Therefore, the scope and severity for 42 CFR(s): §483.25(d)(1)(2) - Accidents/Supervision (F689) was lowered from an "L" level of scope and severity to an "F" while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.

Findings include:

Review of the facility's "Resident Acknowledgement - Facility Smoking Policy", revised on 08-11-2020 revealed: "Safe Smoking Environment: It is the responsibility of the facility to provide a safe and hazard free environment for those residents having been assessed as safe for Facility smoking privileges. The Oxygen cylinders will not be permitted in any authorized smoking area. Facility smoking policies through verbal means, distribution and posting. This policy is intended to minimize the risks to: Residents who smoke, including possible adverse effects on treatment, passive smoke to others, and fire. Smoking Accommodation: This policy does not include chewing tobacco. Residents may maintain their own tobacco supplies in their room and do not have to be supervised. E-Cigarettes will be treated like cigarettes per policy. At no time will E-Cigarettes be permitted for use inside of the facility. The smoking of marijuana is prohibited in an Nexion Facility. The facility is

safety. On 2/21/21 at 4:40 PM Nurse Practitioner (NP)#1 assessed a total of twenty-three (23) Residents which previously resided in affected area. No concerns identified. On 02/24/21 Psychiatric Nurse Practitioner (NP) assessed a total of twenty-three (23) Residents for any emotional distress or trauma as related to the fire with no abnormalities noted. Staff Support hotline posted to provide grief or mental health support due to fire. On 02/21/21 at 5:02 PM Mississippi State Department of Health was notified of event. On 02/21/21 at 6:30 PM Fire Marshall assessed building for any safety issues regarding the fire and cleared the remaining unaffected area to allow occupancy. On 02/21/21 at 6:30 PM Resident rooms involved in evacuation area were assessed for water damage by outside contractor and Residents were actively being relocated to other areas of the building by facility staff. Relocation of twenty-three (23) Residents were completed by 10:30PM. From 6:30 PM to 10:30 PM Responsible Parties of Residents residing in facility were contacted regarding event and safety of Residents by administration staff. On 02/21/21 beginning at approximately 8:00 PM Administrator, Director of Nurses (DON), and Staff Development Coordinator (SDC) initiated education with staff, including Certified Nursing Assistants, licensed nurses, housekeeping staff, business office staff, therapy staff, dietary staff and administrative staff on Abuse and Neglect

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F 689	Continued From page 5 responsible for enforcement of smoking policies. Smoking is prohibited in any room, ward, or compartment within the facility with exception being the designated smoking room on the first floor. Smoking is prohibited where flammable liquids, combustible gas or oxygen are stored, and in any other hazardous location. These areas are posted with "nonsmoking area" signs. Residents wishing to smoke while at the facility will have a "Smoking Safety Evaluation" completed by the interdisciplinary team to determine the resident's ability to follow smoking policies safely. All residents who wish to smoke must provided finds to purchase their own smoking paraphernalia. Oxygen carrying devices will not be permitted in any authorized smoking area. Check Option that applies to facility: 1. All smoking in this facility is SUPERVISED and at designated times. Staff will maintain/keep all smoking materials (e.g., cigarettes, pipes, matches, lighters, lighter fluid) and distribute the materials to residents at smoking times. 2. Residents who are deemed "safe" will be allowed to smoke unsupervised and may be permitted to keep cigarettes on their persons. If resident is deemed "unsafe", they will be required to surrender all smoking paraphernalia to facility. Staff will maintain/keep all smoking materials (e.g., cigarettes, E-Cigarettes, pipes, matches, lighters, lighter fluid) and distribute the materials to residents at smoking times. Furthermore, a smoking schedule will be posted, and resident will be required to smoke with supervision only, according to schedule. Smoking Infraction: The first infraction of the smoking policy results in a warning. This warning may be verbal. The warning is given to both the resident and their family member of contact. a	F 689	Prohibition Policy, Resident Rights, Emergency Operations Plan, Fire Evacuation, Smoking Evaluations, and Resident Safety regarding fire. No staff will be allowed to return to work without completing. On 02/22/21 at 5:00PM, facility Administrator initiated automated phone reporting system alert to Resident families and staff to inform smoking safety including facility storage of lighters, asking families not to purchase flammable materials including new revisions to policy with removal of lighters regardless of smoking safety status. On 03/08/21 at 8:40PM facility Administrator initiated automated phone reporting system with updated alert including revisions on smoking policy with facility storage of all smoking materials and assigned smoking times. This system automatically sends alerts and contacts families and staff listed in Resident□s record and payroll system. On 02/23/21 at 4:30 PM, the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing (Infection Preventionist) , Nurse Practitioner, and Clinical Corporate Consultant held Quality Assurance Performance Improvement meeting to include immediate corrective actions following facility fire involving audits on facilities current smoking Residents with room checks, smoking evaluations, smoking safety equipment, room change notifications, updated Brief Interview Mental Staus (BIMS), and care plan reviews. Smoking policy was discussed with revision to remove wording that residents may retain their lighters if	

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F 689	Continued From page 6	F 689		

safe smoking reassessment of that resident is performed to determine supervision required. The second infraction of the smoking policy may result in notice of discharge. The reason for discharge would be endangerment to the health and safety of residents."

On 03-03-2021, at 7:20 PM, during an interview with the Administrator she stated Resident #1, the resident who started the facility fire, was his own Resident Representative (RR). His Brief Interview for Mental Status (BIMS) score was 15 deeming him able to make his own decisions. He left the facility three (3) times a week for dialysis and would come and go as he pleased. She felt it was a violation of his rights for the staff to go through his belongings every time he would return from an outing. She stated she was aware there were several residents that probably had lighters before the fire because they were not consistently going through the smoker's belongings or monitoring what they were getting in packages from family or for themselves. The administrator stated there were several lighters confiscated after the fire, and the new smoking rules were reviewed with each smoker. When asked by the SA if they had removed all the lighters from the current smokers, she stated, she hoped so, but they did not go through every drawer, and closet. They took what they were able to find, and what the residents gave to them. She again stated, several of them went out on pass as their own RP and they were not searched when they came back. She stated they had hired staff to do supervised smoking from 8:00 AM - 10:00 PM. The Nurse Practitioner (NP) came and assessed everybody after the fire to check for smoke inhalation and they had the "Psych" provider come and assess residents for Post-Traumatic

deemed safe. Resident□s room checks were initiated on 2/21/21 with smoking residents to remove all lighters. Room checks were completed on 2/22/21 with multiple lighters found. On 03/08/21 at 6:45 PM, the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing and Clinical Corporate Consultant held Quality Assurance Performance Improvement meeting following notification of Immediate Jeopardy to review steps initiated to prevent any further reoccurrence including new policy and procedure changes. The smoking policy was revised to include supervised smoking of all Residents, assigned smoking times, and facility storage of all smoking material. On 02/24/21 at 11:01 AM final written investigation was sent to Mississippi Department of Health along with Mississippi State Attorney General at 4:55 PM. On 03/03/21 at 11:00AM Mississippi State Department of Health Life Safety Surveyor entered facility to assess affected area with no negative findings. On 03/08/21 at 3:45pm E-cigarettes and smoking materials removed from Resident #2 possession, Assistant Director of Nurses (ADON) and Social Service Director (SSD) attempted education on new smoking policy and Resident #2 declined education. At 6:00 PM Smoking evaluation completed by Director of Nurses (DON) on Resident #2 revised to indicate Supervised smoking in designated smoking area during assigned smoking times. On 3/9/21 100% room checks of all one hundred and thirty-one

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F 689	Continued From page 7	F 689		

Stress Disorder (PTSD) from the event. They are committed to doing random checks for lighters, etc., five (5) times a week for four (4) weeks, then three (3) times a week for 4 weeks and then as needed. The Administrator stated they had revised the smoking policy to include the first infraction would be a verbal warning and the second infraction could result in a 30 discharge being issued.

Resident #1

Record review of Resident #1's Face Sheet revealed he was admitted to the facility on 07-14-2020 was diagnoses of End Stage Renal Disease, Dialysis Dependent, Gastric Esophageal Reflux Disease, Chronic Pain, Anemia, and Bilateral Below the Knee Amputations.

His latest quarterly Minimum Data Set (MDS) dated 01-21-21 indicated he had a Brief Interview for Mental Status (BIMS) score of 15 and was able to make his own decisions. He had no stated behaviors and required supervision up to limited assistance of one staff member for most of his activities of daily living (ADL's).

Review of his Nurses Notes (NN) dated 02-16-2021, at 10:44 PM, indicated he had altered mental status, had not been to dialysis in a week, and was requesting to go to the hospital.

Record review of Resident #1's "Abstract Summary" from the hospital, completed on 03-02-2021, revealed his hospital diagnoses to be Fluid Overload secondary to missed dialysis for 1 week, Metabolic Brain Disorder, and an Abrasion to his right hip.

(131) resident□s room were initiated to remove all smoking materials. No lighters were found. Two electronic cigarettes were removed to include Resident #2. There are no Residents with possession of smoking materials completed on 3/9/21 at 9:00 am. On 03/08/21 at 6:00PM Director of Nursing (DON) initiated new smoking evaluations on residents along with care plan updates on resident that smoke reflecting safety needs and policy changes. One hundred and Thirty-one (131) Resident smoking evaluations were completed with Twenty-one (21) Resident smoking care plans adjusted. On 3/9/21 at 7:30 am door to smoking area was secured, and scheduled smoking times begin starting at 9:00 am. On 03/08/21 beginning at approximately 7:00 PM Staff Development Coordinator (SDC) initiated education with staff, including Certified Nursing Assistants, licensed nurses, housekeeping staff, business office staff, therapy staff, dietary staff, and administrative staff on new smoking policy revisions. No staff will be allowed to return to work without completing. On 03/09//21 at 9:15AM education begin on new smoking policy revision with current smoking residents and smoking materials removed from current smoking resident's possession to include lighters, and cigarettes, on 03/09/21 at 8:30AM keypad locked entry located at designated smoking area on lower first floor activated to ensure supervised access followed. On 03/09/21 at 10:15 AM Resident Council Meeting Held with Activities Director, Resident Council President, and fifteen

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F 689	Continued From page 8 A Physicians Progress Note from the hospital, dated 02-18-2021 at 12:40 PM, indicated the following plan: Volume overload from dialysis noncompliance - based on his behavior since admission, I would say he has been refusing dialysis, will continue to dialyze here for volume control...since he is refusing all medications, there is nothing I can do for him. Will ask for psych eval, perhaps he would be a (Geriatric Psych Unit) GPU candidate. If not, he will have to be discharged back to his home facility soon." Record review of a Wound Consult note from the hospital, dated 02-18-2021, at 1:05 PM, stated, "Patient confused, somewhat aggressive, unable to provide any history on the wounds." Record review of a NN dated 02-20-21 at 10:57 PM, indicated he had returned from the hospital and voiced no complaints. A Smoking Safety Evaluation dated 02-20-21 at 9:00 PM stated he was identified as a safe smoker. Record review of a NN dated 02-21-2021, at 12:13 PM, revealed he was lethargic but able to answer questions, he was total care for personal hygiene, bathing, dressing, and transfers and had to use a mechanical lift to transfer. His appetite was noted as poor. Record review of a NN dated 2-21-21, at 1:00 PM, revealed the nurse was sitting at the desk, heard the smoke alarm, noticed smoke coming from Resident #1's room. She grabbed the fire extinguisher, opened the door and smoke and water poured out. She attempted to go into his	F 689	(15) resident members present to discuss new smoking policy revisions with supervised smoking times, and changes in facility storage of smoking materials. Facility is alleging that all activities to remove the Immediate Jeopardy were completed as of 03/09/21, and the Immediate Jeopardy was removed 03/10/21. 2. On 03/08/21 the Director of Nursing (DON) initiated new smoking evaluations on all current Residents with care plan updates for Residents who smoke reflecting safety needs. On 03/09/21 100 percent checks of all one hundred and thirty-one Residents' rooms were initiated to remove all smoking materials. No lighters were found. Two electronic cigarettes were removed to include Resident#2. One hundred and thirty- one (131) residents have the potential to be affected. 3. On 03/09/21 education begin by Social Services Director and/or Social Services assistant with all current smoking Residents on new smoking policy revisions to include supervised smoking times and facility storage of smoking materials. On 03/09/21 keypad locked entry located at designated smoking area on lower first floor activated by Maintenace Director to ensure supervised access. 4. Beginning on 03/09/21 the Administrator and/or Director of Nursing will monitor at least five Residents weekly for four weeks and then three residents monthly for three months for compliance with supervised smoking and facility	

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F 689	Continued From page 9 room but was unsuccessful due to smoke, so she called his name and after approximately 1 minute, heard the resident yell "yall help me". The nurse supervisor and a Certified Nurse Aide (CNA) went in, put him in a wheelchair and rolled him out of the room. They put him in room 107 to assess him. 911 was called and he was sent to the local burn unit. Record review of a NN dated 02-21-21, at 5:31 PM, titled "Incident Note" stated the "Fire alarm was automatically activated, heavy dark smoke and copious amounts of water was noted coming from room 102 D. Resident noted in the room lying on the floor by the foot of the bed calling out "help me". Res. was transferred to wheelchair then to safety by staff. Burns were noted on the resident's upper right chest, right arm, and upper right back. Resident stated he had a cigarette lighter to light his cigarette but did not reveal where he got the lighter." Record review of a NN dated 02-21-21, at 10:59 PM, revealed, "called (name of local burn unit) to get report on resident and was told he was doing well and was being admitted to the hospital." Record review of an additional Smoking Safety Evaluation that was completed on 02-21-21 at 11:00 PM, after Resident #1 had been admitted to the hospital, indicated his mental status was alert, decision ability was consistent, his reflexes were quick response, he did NOT only smoke in designated areas, he could safely light and hold a cigarette, he responds quickly to fallen ashes, he did NOT follow the smoking guidelines, he returned his smoking materials to storage, he did not remove his oxygen tubing, and could extinguish his own cigarette.	F 689	storage by facility policy. A report was be submitted on 3/17/21 to the Quality Assurance Performance Improvement for review and recommendations and will continue monthly for three months. The DON is responsible for monitoring and compliance.	

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The Evaluation further states, "if one response is answered "no" then resident should be supervised while smoking". There were several items marked "no" on the form, yet the "Summary of Evaluation" indicated he was "safe to smoke unsupervised", and the "Comments" stated "Resident has been deemed as an unsafe smoker, he has a BIMS of 15 and chooses to smoke unsafely. Resident smokes while O2 is in use while in the bed."

On 03-08-2021, at 10:45 AM, during an interview with the Social Services Director (SSD), when asked if she felt the Smoking Safety Evaluation done on Resident #1's readmission to the facility had been accurate given the hospital was referring to him as confused, and the nurses had charted he was lethargic, she stated, "probably not, since he was smoking in his room, he may have just answered their admission questions right."

During an interview on 3/8/21, at 11 AM, multiple areas of contradiction on the "Smoking Safety Evaluation" form which had been completed on 2/21/21, at 11PM, was reviewed with the Administrator. She agreed the evaluation was not accurately completed and contradictory to itself in several places. She feels it was done hurriedly and attention was not paid to the details on the form.

Review of Resident #1's diagnosis list sent from the hospital on 03-04-2021, indicated his primary diagnosis was "Burns with skin graft except extensive 3rd degree burns", and his secondary diagnosis was " Full thickness burns with skin grafts or inhalation injury".

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Resident #1's diagnosis list continued to include 3rd degree burns to his trunk, right upper arm, right lower back, and chest wall, with excision of the subcutaneous fat layer and fascia of his back, right upper arm, chest, and right trunk, and replacement transfers of his back, right upper arm and chest.

Record review of a "Discharge Report", dated 02-28-2021, from the hospital which revealed, he was taken to surgery for a second time for excision of devitalized tissue and had skin grafts placed. After surgery he was alert and responsive however he was having hypertensive episodes. Laboratory (Lab) staff went in during the night to obtain blood work and he was found unresponsive with no vital signs deceased in the bed. He was a Do Not Resuscitate (DNR).

Resident #2

Review of Resident #2's Face Sheet revealed she was admitted to the facility on 05-02-2018, with diagnoses of Quadriplegia - C5 - C7 incomplete, Anxiety, Insomnia, Gastro-esophageal Reflux Disease, Deep Tissue Injury (DTI) of the left heel, Pain, and Constipation.

Record review of her latest MDS dated 12-28-2020, revealed she had a BIMS of 15 and was able to make her own decisions regarding her care, she required total assistance of two (2) staff members for her ADL's, and the use of a mechanical lift for transfers.

Review of Resident #2's nurses notes (see below) revealed multiple times in which she had exhibited behaviors such as the use of foul

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language, false accusations against staff, refusal to be educated on the new smoking policies, and refusal of all medications except for her pain pill.

Review of NN, dated 02-10-2021 at 1:22 PM, revealed " ...asked to speak to someone in charge ...with a smile and smirk said (formal name of aide) called her a derogatory name ...After the DON and social worker left the room, resident with a laugh and smirk said "I want (formal name of aide) (derogatory word) sent home ..."

Review of NN, dated 02-11-2021 at 11:00 AM, revealed, "Resident refuses to allow SW (social worker) in her room to receive education on smoking policy, rules and guidelines ..."

Review of NN dated 03-01-2021 at 9:40 AM, revealed, " ...Resident raising her voice and using profanity because she didn't want any of her medication except her pain pill ..."

Review of Resident #2's Care Plan for smoking stated, "(Formal Name) is a smoker. She has been educated on the new smoking policy and has been deemed safe to smoke unsupervised. On 10-01-2018, - resident was observed with burn marks to her fingers. She states that the burns did not come from smoking cigarettes. Resident refused to smoke while supervised. 10-14-2019 - Resident uses vapor cigarettes. 02-22-21 - chooses not to do BIMS assessment."

Record review of Resident #2's 02 Smoking Safety Evaluation dated 02-23-2021, at 10:11 AM, revealed, her manual dexterity is weak, and her grasp is weak, she drops items, her reflexes are diminished in response, she has upper and lower

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body limitations, she smokes only in designated areas, and cannot safely light her smoking material, she cannot safely hold her smoking material, she can dispose of her ashes, and can quickly respond to fallen ashes, she follows the smoking guidelines per policy, and returns her smoking materials to storage.

There is a note on the evaluation which states, "if one response is answered "NO" then resident should be supervised while smoking" She has 3 "NO"s on her form and yet under the "Summary of Evaluation" it stated she can smoke "unsupervised". In the "Comments" section it stated, "resident has upper and lower body impairments, she requires assistance with lighting cigarettes, resident is able to grasp cigarette but r/t upper body impairments, she is at risk for dropping items."

During an interview on 3/8/21, at 11 AM, multiple areas of contradiction on the "Smoking Safety Evaluation" form which had been completed on 2/21/21, at 11 PM, was reviewed with the Administrator. She agreed the evaluation was not accurately completed and contradictory to itself in several places. She feels it was done hurriedly and attention was not paid to the details on the form. She stated she was aware Resident #2 refused to get out of bed to go smoke and smoked her E-cigarette unsupervised in her room all the time. She stated she "needed to be given a 30-day discharge because she had refused to abide by the rules since her admission."

On 03-05-2021, at 11:30 AM, the SA was asked to visit Resident #2, at her request. While meeting with her, an E-cigarette was observed on her bedside table with two battery cartridges.

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When asked if she was allowed to smoke in her room, she stated, "Hell Yeah, because that is not a real cigarette anyway, I ain't no harm to no body".

On 03-05-2021, at 1:45 PM., during an interview with R.N.#1, she verified Resident #2 was allowed to smoke her E-cigarette unsupervised in her room because she refused to get out of the bed to go smoke and she refused to be supervised while she was smoking. She stated the management was aware and let her do it.

Resident #3

Record review of Resident #3's Face Sheet revealed she was admitted to the facility on 12-11-2017 with diagnoses of Chronic Obstructive Pulmonary Disease, Polyneuropathy, Hypertension, Insomnia, Depression, Anxiety and Gastroesophageal Reflux.

Record review of Resident #3's last Quarterly MDS dated 12-18-2020 revealed she had a BIMS of 15 and was able to make her own decisions, and required extensive assistance to get dressed every day, and supervision of staff for all others.

Record review of Resident #3's Smoking Care plan revealed an added intervention, dated 03-01-2021 that stated, "Resident had cigarette lighter. SW counseled with resident about smoking policy."

During an interview on 03-08-2021 at 11:20 AM with the SSD, she was asked if the date reflected the date, she removed the lighter from Resident #3, or just the date she entered the intervention,

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as 03-01-2021 would have been eleven (11) days after the fire this resident had access to a lighter. She stated, "I'm unable to say right now, I don't remember all the dates."

On 03-04-2021, at 10:10 AM, during an interview with Resident #3, she stated, " I don't have a lighter no more, since they came and got them a week ago. I'll be honest, I don't' know if I still got some of them stashed in all those boxes or not. We been moved around so much for the virus and then the fire that all my stuff is in boxes right now. I keep my cigarettes in my purse." The SA observed a pack of cigarettes laying on her bedside table and another one sticking out of one of her clothing drawers.

Resident #4

Record review of Resident #4's Face Sheet revealed she was re-admitted to the facility on 12-31-2020, with diagnoses of Alcoholic Dependence in Remission, Cirrhosis of the Liver, Anemia, Depression, Anxiety, Hypertension, Overactive Bladder, Fibromyalgia, and Gastroesophageal Reflux.

Record review of Resident #4's latest quarterly MDS dated 01-07-2021, revealed a BIMS score of 15, meaning she is able to make her own decisions, and required supervision for all her ADL's.

On 03-04-2021, at 10:15 AM, during an interview with Resident #4, she stated, "I keep my cigarettes in my purse next to my bed. I don't have a lighter anymore since the staff came and took them after the fire. Somebody is usually out

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there from around 8 am - 10 pm, but the weekends are real bad. Last weekend there was nobody here to do the smoking for us all day on Sunday, so we had a staff member light a cigarette for one of us, and then we just tried to light each other's for everybody as they came out the rest of the day. I go out and smoke 10-12 times a day, and there is usually 5-6 times a week that no staff member is out there. There is a couple guys that need help smoking, so if they come out there when no staff is there, we try to remember to help put on their aprons and light their cigarettes for them. We try to watch out for each other."

Resident #5

Review of Resident #5's Face Sheet revealed, he was admitted to the facility on 11-03-2011 with diagnoses of Intercostal Neuropathy, Hypertensive Heart Disease with Heart Failure, Kachin-Beck Disease, Osteoarthritis, and Pain.

Record Review of Resident #5's latest quarterly MDS, dated 02-19-2021, revealed a BIMS score of 14, making him able to make his own decisions, and requiring supervision for most of his ADL's, except for putting on his clothing, due to only having one arm.

On 03-04-2021, at 10:30 AM, during an interview with Resident #5, he stated, "I keep my cigs in my room in that lock drawer over there, but I don't have no lighter anymore. They came and took it after that guy lit the place up. If they find a lighter on you, you get a 30-day notice and I been here for almost 6 years. From 8 am-1 there is usually a staff member out there with us, but if no one is out there, we light off each other out of respect for

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the staff, not having to come out here while they are trying to work. (Formal name of another resident) needs help to smoke, cuz his hands shake so bad, so we try to help him when he rolls out without help...I am out here smoking most of the day. I go in to eat and to take a nap."

Resident #6

Record review of Resident #6's Face Sheet revealed, she was admitted to the facility on 03-25-2020 with diagnoses of Biliary Cirrhosis, Bipolar Depression, Anemia, Liver Disease, Chronic Kidney Disease - Stage 4, and Insomnia.

Record review of Resident #6's latest quarterly MDS, dated 02-18-2021, revealed she has a BIMS of 15, making her able to make her own decisions, and she required supervision for all of her activities of daily living.

On 03-04-2021, at 11:38 AM, during an interview with Resident #6, she stated, "There are several times a week when there ain't no staff out there for us. This past Sunday there was only a staff out there one time, and that is cuz they wanted to smoke. (Formal name of another resident) needs help to smoke and the aides sometimes push him out and put his apron on and then leave, so we light his cigarette for him."

Resident #7

Record review of Resident #7's Face Sheet revealed, he was admitted to the facility on 07-12-2019 with diagnoses of Polyneuropathy, Rheumatoid Arthritis, Chronic Viral Hepatitis C,

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Depression, Insomnia, and Diabetes Type II.

Review of Resident #7's latest quarterly MDS dated 12-14-2020, revealed he has a BIMS score of 15, making him able to make his own decisions, and he required limited assistance for all of his activities of daily living.

On 03-04-2021, at 11:20 AM, during an interview with Resident #7, he stated, "I keep my cigarettes in my pocket or my hat, I don't have a lighter anymore since they came and took them from us. I usually go down there about three times a day and if staff are there, they will light our cigarettes. There is usually someone out there until after 10:00 o'clock at night. If not, we will light each other's cigarettes. (Formal name of another resident) is the man that needs help there and he rolls himself outside. His handshakes bad, so I helped him put the cigarette in his mouth and then we light it with our own cigarettes. There don't always be staff out there all the time when we are smoking. We try to make sure he has his apron on, but I'm sure sometimes he does not... We try to lookout for each other out there to make sure everybody is OK."

On 03-07-2021, at 11:10 AM, an observation was made of a letter given to all the smokers, posted on the wall next to their beds. The letter revealed, "Effective 2/15/2021 Yazoo City Rehabilitation and Healthcare Center will go to supervised smoking for all residents. At this time, the facility will take control of all smoking paraphernalia including cigarettes, lighters, tobacco pipes, etc. These will be kept in a lock box in the medication room on the first floor and will be brought out for the smoking times. Smoking times are as follows: 7:30, 8:30, 10:15, 1:00. 3:45, 6:00, 8:00 and 9:30.

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Each smoking time will be 15 to 20 minutes long depending on the number of smokers. Failure to follow these rules will result in to a thirty-day discharge notice being issued."

On 03-07-2021, at 2:15 PM, during an interview with the Activities Director (AD), she stated there were two people that needed support to smoke. They were to wear aprons at all times while smoking. One resident could not hold his own cigarette due to shaking from Parkinson's disease, and the other would often fall asleep when smoking and would drop his cigarette on himself. She stated they had activity staff that stayed outside with the residents from around 8:00 am - 10:00 pm. When asked by the SA what a resident was supposed to do if they wanted to smoke a cigarette at 2:00 AM, she stated they would have to find a staff member willing to light their cigarette for them and sit with those that need to be helped. When asked by the SA about the letter posted beside the beds of all the smokers, she stated the facility was not following the letter because of the uproar the residents made regarding locking up their cigarettes, and not being able to smoke whenever they wanted to, like they are now.

The facility submitted an acceptable Removal Plan on 03-09-2021, at 4:40 PM, in which the facility alleged all corrective actions to remove the IJ were completed on 03-09-2021 and the IJ was removed on 03-10-2021.

Removal Plan

Brief Summary of Events

On 2/21/21 at 3:06 PM Licensed Practical Nurse

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(LPN) #1 reported hearing fire alarm sounding. She reported grabbing fire extinguisher and seeing smoke coming out of Resident #1 room. LPN #1 reported calling Residents #1 name and he hollered back help. LPN #1 reported entering room with fire extinguisher, described as thick black smoke with water present, no active fire. LPN #1 did not use fire extinguisher. LPN #1 reported unable to see through the smoke and then RN (Registered Nurse) #1 and CNA (Certified Nursing Assistant) #1 went into Resident #1's room noting a smoke-filled room with no fire, sprinkler system actively pouring water, and found Resident #1 located lying on floor near foot of bed with no active fire. RN (Registered Nurse) #1 and CNA (Certified Nursing Assistant) #1 along with Dietary Aide #1 transferred Resident #1 from floor to wheelchair and removed Resident #1 from the room. Resident #1 denied pain and reported he lit a cigarette while wearing oxygen. Resident #1 refused to answer on where he obtained lighter from.

Facility failed to provide adequate supervision ensuring Residents were abiding by established smoking rules/policy regarding smoking materials resulting in Resident #1 obtaining lighter and lighting a cigarette lying in bed with oxygen causing fire in the facility that resulted in burns to right shoulder, chest and back. Resident #2 failing to abide by facility policy with possession of electronic cigarette.

Corrective Actions
1. On 2/21/21 at 3:06 pm Receptionist #1 called 911 while facility alarm was sounding. Alarm company also contacted fire department.

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2. On 02/21/21 at 3:12 pm Fire department dispatched EnRoute to facility and arrived at 3:14 pm. Sprinkler system was actively spraying water causing excessive smoke. Sprinkler system extinguished the fire prior to arrival of Fire Department. On 02/21/21 at 3:15 pm LPN #2 called 911 requested ambulance.

3. On 02/21/21 at 3: 12 PM Resident #1 was assessed by RN (Registered Nurse) #1. Resident #1 had burns to right front and rear shoulder, Right Scapula, and Right side of chest. Ambulance Service arrived at facility at 4:06 PM and begin further evaluation of Resident and transferred to burn center. The facility has no outside legal representative for Resident #1. Resident #1 is his own responsible party. The facility initiated an investigation.

4. On 02/21/21 at 3:15 PM Remaining twenty-three (23) Residents in fire door area begin being escorted to outside parking lot to account for and ensure safety.

5. On 2/21/21 at 4:40 PM Nurse Practitioner (NP)#1 assessed a total of twenty-three (23) Residents which previously resided in affected area. No concerns identified. On 02/24/21 Psychiatric Nurse Practitioner (NP) assessed a total of twenty-three (23) Residents for any emotional distress or trauma as related to the fire with no abnormalities noted. Staff Support hotline posted to provide grief or mental health support due to fire.

6. On 02/21/21 at 5:02 PM Mississippi State Department of Health was notified of event.

7. On 02/21/21 at 6:30 PM Fire Marshall

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assessed building for any safety issues regarding the fire and cleared the remaining unaffected area to allow occupancy.

8. On 02/21/21 at 6:30 PM Resident rooms involved in evacuation area were assessed for water damage by outside contractor and Residents were actively being relocated to other areas of the building by facility staff. Relocation of twenty-three (23) Residents were completed by 10:30 PM. From 6:30 PM to 10:30 PM Responsible Parties of Residents residing in facility were contacted regarding event and safety of Residents by administration staff.

9. On 02/21/21 beginning at approximately 8:00 PM Administrator, Director of Nurses (DON), and Staff Development Coordinator (SD) initiated education with staff, including Certified Nursing Assistants, licensed nurses, housekeeping staff, business office staff, therapy staff, dietary staff and administrative staff on Abuse and Neglect Prohibition Policy, Resident Rights, Emergency Operations Plan, Fire Evacuation, Smoking Evaluations, and Resident Safety regarding fire. No staff will be allowed to return to work without completing.

10. On 02/22/21 at 5:00 PM, facility Administrator initiated automated phone reporting system alert to Resident families and staff to inform smoking safety including facility storage of lighters, asking families not to purchase flammable materials including new revisions to policy with removal of lighters regardless of smoking safety status. On 03/08/21 at 8:40 PM facility Administrator initiated automated phone reporting system with updated alert including revisions on smoking policy with facility storage of all smoking materials and

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assigned smoking times. This system automatically sends alerts and contacts families and staff listed in Resident's record and payroll system.

11. On 02/23/21 at 4:30 PM, the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing (Infection Preventionist) , Nurse Practitioner, and Clinical Corporate Consultant held Quality Assurance Performance Improvement meeting to include immediate corrective actions following facility fire involving audits on facilities current smoking Residents with room checks, smoking evaluations, smoking safety equipment, room change notifications, updated Brief Interview Mental Status (BIMS), and care plan reviews. Smoking policy was discussed with revision to remove wording that residents may retain their lighters if deemed safe. Resident's room checks were initiated on 2/21/21 with smoking residents to remove all lighters. Room checks were completed on 2/22/21 with multiple lighters found.

12. On 03/08/21 at 6:45 PM, the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing and Clinical Corporate Consultant held Quality Assurance Performance Improvement meeting following notification of Immediate Jeopardy to review steps initiated to prevent any further reoccurrence including new policy and procedure changes. The smoking policy was revised to include supervised smoking of all Residents, assigned smoking times, and facility storage of all smoking material.

13. On 02/24/21 at 11:01 AM final written investigation was sent to Mississippi Department of Health along with Mississippi State Attorney

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General at 4:55 PM.

14. On 03/03/21 at 11:00 AM Mississippi State Department of Health Life Safety Surveyor entered facility to assess affected area with no negative findings.

15. On 03/08/21 at 3:45 pm E-cigarettes and smoking materials removed from Resident #2 possession, Assistant Director of Nurses (ADON) and Social Service Director (SSD) attempted education on new smoking policy and Resident #2 declined education. At 6:00 PM Smoking evaluation completed by Director of Nurses (DON) on Resident #2 revised to indicate Supervised smoking in designated smoking area during assigned smoking times. On 3/9/21 100% room checks of all one hundred and thirty-one (131) resident's room were initiated to remove all smoking materials. No lighters were found. Two electronic cigarettes were removed to include Resident #2. There are no Residents with possession of smoking materials completed on 3/9/21 at 9:00 am.

16. On 03/08/21 at 6:00 PM Director of Nursing (DON) initiated new smoking evaluations on residents along with care plan updates on resident that smoke reflecting safety needs and policy changes. One hundred and Thirty-one (131) Resident smoking evaluations were completed with Twenty-one (21) Resident smoking care plans adjusted. On 3/9/21 at 7:30 am door to smoking area was secured, and scheduled smoking times begin starting at 9:00 am.

17. On 03/08/21 beginning at approximately 7:00 PM Staff Development Coordinator (SDC)

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initiated education with staff, including Certified Nursing Assistants, licensed nurses, housekeeping staff, business office staff, therapy staff, dietary staff, and administrative staff on new smoking policy revisions. No staff will be allowed to return to work without completing.

18. On 03/09//21 at 9:15 AM education begin on new smoking policy revision with current smoking residents and smoking materials removed from current smoking resident's possession to include lighters, and cigarettes, on 03/09/21 at 8:30 AM keypad locked entry located at designated smoking area on lower first floor activated to ensure supervised access followed.

19. On 03/09/21 at 10:15 AM Resident Council Meeting Held with Activities Director, Resident Council President, and fifteen (15) resident members present to discuss new smoking policy revisions with supervised smoking times, and changes in facility storage of smoking materials.

20. Facility is alleging that all activities to remove the Immediate Jeopardy were completed as of 03/09/21, and the Immediate Jeopardy was removed 03/10/21.

The SA validated the Removal Plan on 03-11-2021, and determined the IJ was removed on 03-10-2021, prior to exit. Therefore, the scope and severity for 42 CFR(s): §483.70 -Administration (F835) was lowered from an "L" to an "F", while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory compliance.

1. On 2/21/21 at 3:06 PM Receptionist #1 called

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911 while facility alarm was sounding. Alarm company also contacted fire department.
- Verified by the SA via review of the call log and interview.

2. On 02/21/21 at 3:12 pm Fire department dispatched EnRoute to facility and arrived at 3:14 pm. Sprinkler system was actively spraying water causing excessive smoke. Sprinkler system extinguished the fire prior to arrival of Fire Department. On 02/21/21 at 3:15 PM LPN #2 called 911 requested ambulance.
- Verified by the SA via review of the Fire Departments call log journal and report.

3. On 02/21/21 at 3: 12 PM Resident #1 was assessed by RN (Registered Nurse) #1. Resident #1 had burns to right front and rear shoulder, Right Scapula, and Right side of chest. Ambulance Service arrived at facility at 4:06 PM and begin further evaluation of Resident and transferred to burn center. The facility has no outside legal representative for Resident #1. Resident #1 is his own responsible party. The facility initiated an investigation.
- Verified by the SA through review of Resident #1's medical record.

4. On 02/21/21 at 3:15 PM Remaining twenty-three (23) Residents in fire door area begin being escorted to outside parking lot to account for and ensure safety.
- Verified by the SA through interview of residents, and review of prior census sheet verses current census sheet of locations.

5. On 2/21/21 at 4:40 PM Nurse Practitioner (NP)#1 assessed a total of twenty-three (23) Residents which previously resided in affected

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area. No concerns identified. On 02/24/21 Psychiatric Nurse Practitioner (NP) assessed a total of twenty-three (23) Residents for any emotional distress or trauma as related to the fire with no abnormalities noted. Staff Support hotline posted to provide grief or mental health support due to fire.
- Verified by the SA through interview of residents, and review of visit notes in their medical records.

6. On 02/21/21 at 5:02 PM Mississippi State Department of Health was notified of event.
- Verified by the SA through review of the report.

7. On 02/21/21 at 6:30 PM Fire Marshall assessed building for any safety issues regarding the fire and cleared the remaining unaffected area to allow occupancy.
- Verified by the SA through review of the Fire Marshall's report, and occupy order.

8. On 02/21/21 at 6:30 PM Resident rooms involved in evacuation area were assessed for water damage by outside contractor and Residents were actively being relocated to other areas of the building by facility staff. Relocation of twenty-three (23) Residents were completed by 10:30 PM. From 6:30 PM to 10:30 PM Responsible Parties of Residents residing in facility were contacted regarding event and safety of Residents by administration staff.
- Verified by the SA through resident interview, as most are their own responsible parties, medical record review and family call log review.

9. On 02/21/21 beginning at approximately 8:00 PM Administrator, Director of Nurses (DON), and Staff Development Coordinator (SDC) initiated

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education with staff, including Certified Nursing Assistants, licensed nurses, housekeeping staff, business office staff, therapy staff, dietary staff and administrative staff on Abuse and Neglect Prohibition Policy, Resident Rights, Emergency Operations Plan, Fire Evacuation, Smoking Evaluations, and Resident Safety regarding fire. No staff will be allowed to return to work without completing.
- Verified by the SA through sign-in sheet review and staff interviews.

10. On 02/22/21 at 5:00 PM, facility Administrator initiated automated phone reporting system alert to Resident families and staff to inform smoking safety including facility storage of lighters, asking families not to purchase flammable materials including new revisions to policy with removal of lighters regardless of smoking safety status. On 03/08/21 at 8:40 PM facility Administrator initiated automated phone reporting system with updated alert including revisions on smoking policy with facility storage of all smoking materials and assigned smoking times. This system automatically sends alerts and contacts families and staff listed in Resident's record and payroll system.
- Verified by the SA through review of the transcript provided by "Voice Friend Reporting" and the call times messages were sent out.

11. On 02/23/21 at 4:30 PM, the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing (Infection Preventionist) , Nurse Practitioner, and Clinical Corporate Consultant held Quality Assurance Performance Improvement meeting to include immediate corrective actions following facility fire involving audits on facilities current smoking

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Residents with room checks, smoking evaluations, smoking safety equipment, room change notifications, updated Brief Interview Mental Status (BIMS), and care plan reviews. Smoking policy was discussed with revision to remove wording that residents may retain their lighters if deemed safe. Resident's room checks were initiated on 2/21/21 with smoking residents to remove all lighters. Room checks were completed on 2/22/21 with multiple lighters found.
- Verified by the SA via review of the sign-in sheet, review of the content of the meeting items discussed, and staff interviews.

12. On 03/08/21 at 6:45 PM, the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing and Clinical Corporate Consultant held Quality Assurance Performance Improvement meeting following notification of Immediate Jeopardy to review steps initiated to prevent any further reoccurrence including new policy and procedure changes. The smoking policy was revised to include supervised smoking of all Residents, assigned smoking times, and facility storage of all smoking material.
- Verified by the SA via review of the sign-in sheet, review of the content of the meeting items discussed, and staff interviews.

13. On 02/24/21 at 11:01 AM final written investigation was sent to Mississippi Department of Health along with Mississippi State Attorney General at 4:55 PM.
- Verified by the SA through review of the report received and a copy of the fax sheet that was timed and dated.

14. On 03/03/21 at 11:00 AM Mississippi State Department of Health Life Safety Surveyor

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entered facility to assess affected area with no negative findings.
- Verified by the SA through review of the LSC Surveyors report

15. On 03/08/21 at 3:45pm E-cigarettes and smoking materials removed from Resident #2 possession, Assistant Director of Nurses (ADON) and Social Service Director (SSD) attempted education on new smoking policy and Resident #2 declined education. At 6:00 PM Smoking evaluation completed by Director of Nurses (DON) on Resident #2 revised to indicate Supervised smoking in designated smoking area during assigned smoking times. On 3/9/21 100% room checks of all one hundred and thirty-one (131) resident's room were initiated to remove all smoking materials. No lighters were found. Two electronic cigarettes were removed to include Resident #2. There are no Residents with possession of smoking materials completed on 3/9/21 at 9:00 am.
- Verified by SA via resident interview, reviewing new assessments within the medical records against the checklist of current smokers.

16. On 03/08/21 at 6:00 PM Director of Nursing (DON) initiated new smoking evaluations on residents along with care plan updates on resident that smoke reflecting safety needs and policy changes. One hundred and Thirty-one (131) Resident smoking evaluations were completed with Twenty-one (21) Resident smoking care plans adjusted. On 3/9/21 at 7:30 am door to smoking area was secured, and scheduled smoking times begin starting at 9:00 am.
- Verified by the SA through review of the new smoking assessments dated for 03-08-2021 in

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the medical records of all residents currently in the building.

17. On 03/08/21 beginning at approximately 7:00 PM Staff Development Coordinator (SDC) initiated education with staff, including Certified Nursing Assistants, licensed nurses, housekeeping staff, business office staff, therapy staff, dietary staff, and administrative staff on new smoking policy revisions. No staff will be allowed to return to work without completing.
- Verified by the state agency through review of the sign-in sheet and staff interviews.

18. On 03/09//21 at 9:15 AM education begin on new smoking policy revision with current smoking residents and smoking materials removed from current smoking resident's possession to include lighters, and cigarettes, on 03/09/21 at 8:30 AM keypad locked entry located at designated smoking area on lower first floor activated to ensure supervised access followed.
- Verified by the SA through interviews with the residents who smoke, and the new code pad installed next to the door with numeric code entry to unlock it.

19. On 03/09/21 at 10:15 AM Resident Council Meeting Held with Activities Director, Resident Council President, and fifteen (15) resident members present to discuss new smoking policy revisions with supervised smoking times, and changes in facility storage of smoking materials.
- Verified by the SA through review of the council sign-in form, and resident interview regarding topics discussed and understanding.

20. Facility is alleging that all activities to remove the Immediate Jeopardy were completed as of

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F 689	Continued From page 32 03/09/21, and the Immediate Jeopardy was removed 03/10/21. - The SA verified all aspects of the Removal Plan had been carried out as stated, and the Immediate Jeopardy was removed on 03-10-2021, as stated.	F 689		
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 observation, staff interview, record review and facility policy review, the facility failed to ensure residents who needed respiratory care, were provided such care, consistent with professional standards of practice, to prevent infection for one (1) of nine (9) tracheotomy residents with a current trach infection, Resident #8. Findings Include: Review of the facility policy titled, "Department (Respiratory Therapy) - Prevention of Infection, last revised in November 2011, revealed, "Purpose: The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff...	F 695	1. On 03/03/21 all oxygen tubing supplies, overflow containers and trach mask were replaced by Director of Nursing (DON) charge nurse, RN (Registered Nurse) Supervisor, and Respiratory Therapist to include Resident # 8. 2. An audit was conducted on 03/04/21 by Director of Nurses (DON), Corporate Clinical Consultant (CCS) and Assistant Director of Nurses (ADON)on current Resident with tracheostomy orders to ensure respiratory equipment was with changed and stored properly according to facility policy. Nine (9) Residents had the potential to be affected. 3. Beginning 03/03/21 Education was initiated with Licensed Nurses by Staff	4/9/21

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F 695	Continued From page 33 Infection Control Considerations Related to Oxygen Administration: 7. Change the oxygen cannula and tubing every seven (7) days, or as needed." On 03-03-2021 at 7:00 PM, during a facility tour, accompanied by the Assistant Director of Nursing (ADON), it was noted the facility has 9 residents who require tracheotomies. In going room to room, it was noted all 9 residents had oxygen tubing supplies, over flow containers and trach masks connected to them dated 02-20-2021. The ADON verified the date on each of them. When asked by the SA how often the oxygen tubing for tracheostomy should be changed she stated, "If it is like the other residents on oxygen, it is at least every seven (7) days. However, for tracheostomy it could be more often, our Respiratory Therapy team takes care of all of that for the trach residents. She stated there was one trach resident that had an infection at this time." On 03-03-2021, at 7:40 PM, during an interview with the Administrator and Respiratory Therapist (RT) #1, via the Administrator's cell phone, the SA asked how often the oxygen tubing, over flow containers and trach masks should be changed on trach residents. RT #1 stated "every 7 days unless they get dirty and need changed more often." The SA explained to her that all 9 tracheostomies currently had tubing that was dated 02-20-21. She stated she would "check on them on the 11-7 shift when she came to work, and couldn't believe someone would forget something like that. When asked by the SA what not changing the tubing for a trach resident could be, she stated it "increases the chances of them getting respiratory infections."	F 695	Development Coordinator regarding Tracheostomy care, changing of oxygen tubing, tracheostomy tubing and nebulizer tubing to prevent infections according to facility policy. Beginning on 03/04/21 Licensed Nurses that administered tracheostomy care had to provide return demonstration with Respiratory Therapist on proper techniques with changing of tracheostomy tubing. 4. Beginning on 03/04/21 the Director of Nursing (DON) and /or Assistant Director of Nursing (ADON) began monitoring tracheostomy Residents for Seventy hours (72) hours for any adverse reactions related to failure to change respiratory equipment per facility policy. No adverse reactions noted. Beginning on 03/08/21 weekly rounds conducted by Director of Nursing and/or Assistant Director of Nursing on tracheostomy Resident checking for correct changing and dating of respiratory equipment per facility policy to prevent infection weekly for four weeks then monthly for three (3) months. A report was be submitted on 3/17/21 to the Quality Assurance Performance Improvement for review and recommendations and will continue monthly for three months. The DON is responsible for monitoring and compliance.	

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YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

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F 695	Continued From page 34	F 695		

After the phone conversation was completed, the Administrator stated they don't have RT 24 hours a day in the facility, however, they have a Registered Nurse (RN) assigned to that unit 24 hours a day. They interchange duties to keep the trach residents comfortable and cared for. She agreed the tubing should have been changed and they would take care of finding out who was supposed to change it out on 02-27-2021, and did not, and they would get fresh supplies on the trach residents that night.

Resident #8

Review of Resident #8's medical record revealed she was admitted to the facility on 02-05-2021 with diagnoses of Chronic Obstructive Pulmonary Disease, Chronic Respiratory Failure, Persistent Vegetative State, Anoxic Brain Damage, Tracheostomy Status, Hypertension, Depression, and Seizures.

Resident #8's Minimum Data Set (MDS) dated 02-15-2021 revealed she had a Brief Interview of Mental Status (BIMS) score of 99, meaning she was unable to answer any questions, and is not able to make decisions for herself at this time. She requires total assistance of two staff members for all of her activities of daily living.

Review of Resident #8's Nurses Notes (NN) dated 02-25-2021 at 8:15 AM, revealed, she had "thick tan secretions suctioned from her trach". This note occurs 5 days after her oxygen supplies, and trach mask were due to be changed, and were not.

Review of her NN dated 02-26-2021 at 3:28 PM, revealed a "Change in Condition" report for a

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F 695	Continued From page 35 respiratory infection. It stated, "Resident noted with foul smell in trach, sputum culture order and results noted for Proteus Mirabilis. NP (nurse practitioner) notified and gave new order: Rocephin 1 gram (gm) IM (intramuscular) times (X) 5 days, RP (Responsible Party formal name) notified."	F 695		
F 835 SS=L	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to provide administrative oversight of the smoking program to ensure residents' maintained safety and the highest practicable physical, mental, and psychosocial well-being for 20 of 20 smokers out of 133 residents, with a sample of two (2), Residents #1 and #2. The facility's failure to provide administrative oversight and supervision of the smoking process placed residents at risk, and in a situation, which caused serious injury and death for one (1) resident, Resident #1, and was likely to cause serious injury, harm, impairment, or death for others. The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 02-21-2021, when the facility's failure to	F 835	1. On 03/8/21 at 2:20PM State Agency (SA) notified facility department heads to include Administrator of Immediate Jeopardy (IJ) with substandard quality of care related to accidents/supervision, Administration and Smoking policies. Facility failed to provide adequate supervision ensuring Residents were abiding by established smoking rules/policy regarding smoking materials resulting in Resident #1 obtaining lighter and lighting a cigarette lying in bed with oxygen causing fire in the facility that resulted in burns to right shoulder, chest and back. Resident #2 failing to abide by facility policy with possession of electronic cigarettes. On 2/21/21 at 3:06 pm Receptionist #1 called 911 while facility alarm was sounding. Alarm company also contacted fire department. On 02/21/21	4/9/21

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F 835	Continued From page 36	F 835		

provide administrative oversight and supervision of residents while smoking, failure to ensure they were not smoking in the presence of oxygen (O2) combustible chemicals, and failure to ensure the removal of lighters and combustible materials from residents rooms resulted in a resident smoking in his bed, with his oxygen on, causing a fire in the facility that gave him third degree burns to his right shoulder, right front chest, and right upper back which required extensive skin grafts. He also suffered from inhalation burns, which later contributed to his demise. The facility also had to relocate 23 residents to alternate beds within the facility who incurred loss of personal property, with a loss of 32 beds within the facility to water damage.

On 03-08-2021 at 2:00 PM, the State Agency (SA) informed the Nursing Home Administrator (NHA) of the Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) and provided the Administrator with the IJ Template.

IJ existed at:
42 CFR(s): §483.70 -Administration (F835) - Scope and Severity - "L"

The facility submitted a credible Removal Plan on 03-09-2021 at 4:40 PM, in which the facility alleged all corrective actions to remove the IJ were completed and the IJ removed as of 03-10-2021.

The SA validated the Removal Plan on 03-11-2021 and determined the IJ was removed prior to exit. Therefore, the scope and severity for IJ existed at: 42 CFR(s): §483.70 -Administration (F835) - was lowered from an "L" level of scope and severity to an "F" while the facility develops a

at 3:12pm Fire department dispatched Enroute to facility and arrived at 3:14pm. Sprinkler system was actively spraying water causing excessive smoke. Sprinkler system extinguished the fire prior to arrival of Fire Department. On 02/21/21 at 3:15 pm LPN #2 called 911 requested ambulance. On 02/21/21 at 3: 12PM Resident #1 was assessed by RN (Registered Nurse) #1. Resident #1 had burns to right front and rear shoulder, Right Scapula, and Right side of chest. Ambulance Service arrived at facility at 4:06PM and begin further evaluation of Resident and transferred to burn center. The facility has no outside legal representative for Resident #1. Resident #1 is his own responsible party. The facility initiated an investigation. On 02/21/21 at 3:15 PM Remaining twenty-three (23) Residents in fire door area begin being escorted to outside parking lot to account for and ensure safety. On 2/21/21 at 4:40 PM Nurse Practitioner (NP)#1 assessed a total of twenty-three (23) Residents which previously resided in affected area. No concerns identified. On 02/24/21 Psychiatric Nurse Practitioner (NP) assessed a total of twenty-three (23) Residents for any emotional distress or trauma as related to the fire with no abnormalities noted. Staff Support hotline posted to provide grief or mental health support due to fire. On 02/21/21 at 5:02 PM Mississippi State Department of Health was notified of event. On 02/21/21 at 6:30 PM Fire Marshall assessed building for any safety issues regarding

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plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.

Findings include:

Review of the facility's policy titled, "Resident Acknowledgement - Facility Smoking Policy" revised on 08-11-2020 revealed:
"Safe Smoking Environment: It is the responsibility of the facility to provide a safe and hazard free environment for those residents having been assessed as safe for facility smoking privileges. The Oxygen cylinders will not be permitted in any authorized smoking area. Facility smoking policies through verbal means, distribution and posting. This policy is intended to minimize the risks to: Residents who smoke, including possible adverse effects on treatment, passive smoke to others, and fire.
Smoking Accommodation: This policy does not include chewing tobacco. Residents may maintain their own tobacco supplies in their room and do not have to be supervised. E-Cigarettes will be treated like cigarettes per policy. At no time will E-Cigarettes be permitted for use inside of the facility. The smoking of marijuana is prohibited in a Nexion Facility. The facility is responsible for enforcement of smoking policies. Smoking is prohibited in any room, ward, or compartment within the facility with exception being the designated smoking room on the first floor. Smoking is prohibited where flammable liquids, combustible gas or oxygen are stored, and in any other hazardous location. These areas are posted with "nonsmoking area" signs. Residents wishing to smoke while at the facility will have a "Smoking Safety Evaluation"

the fire and cleared the remaining unaffected area to allow occupancy. On 02/21/21 at 6:30 PM Resident rooms involved in evacuation area were assessed for water damage by outside contractor and Residents were actively being relocated to other areas of the building by facility staff. Relocation of twenty-three (23) Residents were completed by 10:30PM. From 6:30 PM to 10:30 PM Responsible Parties of Residents residing in facility were contacted regarding event and safety of Residents by administration staff. On 02/21/21 beginning at approximately 8:00 PM Administrator, Director of Nurses (DON), and Staff Development Coordinator (SDC) initiated education with staff, including Certified Nursing Assistants, licensed nurses, housekeeping staff, business office staff, therapy staff, dietary staff and administrative staff on Abuse and Neglect Prohibition Policy, Resident Rights, Emergency Operations Plan, Fire Evacuation, Smoking Evaluations, and Resident Safety regarding fire. No staff will be allowed to return to work without completing. On 02/22/21 at 5:00PM, facility Administrator initiated automated phone reporting system alert to Resident families and staff to inform smoking safety including facility storage of lighters, asking families not to purchase flammable materials including new revisions to policy with removal of lighters regardless of smoking safety status. On 03/08/21 at 8:40PM facility Administrator initiated automated phone reporting system with

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F 835	Continued From page 38 completed by the interdisciplinary team to determine the resident's ability to follow smoking policies safely. All residents who wish to smoke must provide funds to purchase their own smoking paraphernalia. Oxygen carrying devices will not be permitted in any authorized smoking area. Check Option that applies to facility: 1. All smoking in this facility is SUPERVISED and at designated times. Staff will maintain/keep all smoking materials (e.g., cigarettes, pipes, matches, lighters, lighter fluid) and distribute the materials to residents at smoking times. 2. Residents who are deemed "safe" will be allowed to smoke unsupervised and may be permitted to keep cigarettes on their persons. If resident is deemed "unsafe", they will be required to surrender all smoking paraphernalia to facility. Staff will maintain/keep all smoking materials (e.g., cigarettes, E-Cigarettes, pipes, matches, lighters, lighter fluid) and distribute the materials to residents at smoking times. Furthermore, a smoking schedule will be posted, and resident will be required to smoke with supervision only, according to schedule. Smoking Infraction: The first infraction of the smoking policy results in a warning. This warning may be verbal. The warning is given to both the resident and their family member of contact. A safe smoking reassessment of that resident is performed to determine supervision required. The second infraction of the smoking policy may result in notice of discharge. The reason for discharge would be endangerment to the health and safety of residents." Resident #1 Record review of a NN dated 02-21-21, at 5:31	F 835	updated alert including revisions on smoking policy with facility storage of all smoking materials and assigned smoking times. This system automatically sends alerts and contacts families and staff listed in Resident□s record and payroll system. On 02/23/21 at 4:30 PM, the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing (Infection Preventionist) , Nurse Practitioner, and Clinical Corporate Consultant held Quality Assurance Performance Improvement meeting to include immediate corrective actions following facility fire involving audits on facilities current smoking Residents with room checks, smoking evaluations, smoking safety equipment, room change notifications, updated Brief Interview Mental Status (BIMS), and care plan reviews. Smoking policy was discussed with revision to remove wording that residents may retain their lighters if deemed safe. Resident□s room checks were initiated on 2/21/21 with smoking residents to remove all lighters. Room checks were completed on 2/22/21 with multiple lighters found. On 03/08/21 at 6:45 PM, the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing and Clinical Corporate Consultant held Quality Assurance Performance Improvement meeting following notification of Immediate Jeopardy to review steps initiated to prevent any further reoccurrence including new policy and procedure changes. The smoking policy was revised to include supervised	

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PM, titled "Incident Note" stated the "Fire alarm was automatically activated, heavy dark smoke and copious amounts of water was noted coming from room 102 D. Resident noted in the room lying on the floor by the foot of the bed calling out "help me". Res. was transferred to wheelchair then to safety by staff. Burns were noted on the resident's upper right chest, right arm, and upper right back. Resident stated he had a cigarette lighter to light his cigarette but did not reveal where he got the lighter."

A Smoking Safety Evaluation dated 02-20-21 at 9:00 PM revealed Resident #1 was identified as a safe smoker.

An additional Smoking Safety Evaluation was completed on 02-21-21 at 11:00 PM, after Resident #1 had been admitted to the hospital, that indicated his mental status was alert, decision ability was consistent, his reflexes were quick response, he did NOT only smoke in designated areas, he could safely light and hold a cigarette, he responds quickly to fallen ashes, he did NOT follow the smoking guidelines, he returned his smoking materials to storage, he did not remove his oxygen tubing, and could extinguish his own cigarette. The Evaluation further states, "if one response is answered "no" then resident should be supervised while smoking". There were several items marked "no" on the form, yet the "Summary of Evaluation" indicated he was "safe to smoke unsupervised", and the "Comments" stated "Resident has been deemed as an unsafe smoker, he has a BIMS of 15 and chooses to smoke unsafely. Resident smokes while O2 is in use while in the bed."

On 03-03-2021, at 7:20 PM, during an interview

smoking of all Residents, assigned smoking times, and facility storage of all smoking material. On 02/24/21 at 11:01 AM final written investigation was sent to Mississippi Department of Health along with Mississippi State Attorney General at 4:55 PM. On 03/03/21 at 11:00AM Mississippi State Department of Health Life Safety Surveyor entered facility to assess affected area with no negative findings. On 03/08/21 at 3:45pm E-cigarettes and smoking materials removed from Resident #2 possession, Assistant Director of Nurses (ADON) and Social Service Director (SSD) attempted education on new smoking policy and Resident #2 declined education. At 6:00 PM Smoking evaluation completed by Director of Nurses (DON) on Resident #2 revised to indicate Supervised smoking in designated smoking area during assigned smoking times. On 3/9/21 100% room checks of all one hundred and thirty-one (131) resident□s room were initiated to remove all smoking materials. No lighters were found. Two electronic cigarettes were removed to include Resident #2. There are no Residents with possession of smoking materials completed on 3/9/21 at 9:00 am. On 03/08/21 at 6:00PM Director of Nursing (DON) initiated new smoking evaluations on residents along with care plan updates on resident that smoke reflecting safety needs and policy changes. One hundred and Thirty-one (131) Resident smoking evaluations were completed with Twenty-one (21) Resident smoking care plans adjusted. On 3/9/21 at 7:30 am door to smoking area was

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F 835	Continued From page 40	F 835		

with the Administrator, she stated Resident #1, the resident who started the facility fire, was his own Resident Representative (RR). His Brief Interview for Mental Status (BIMS) score was 15 deeming him able to make his own decisions. He left the facility three (3) times a week for dialysis and would come and go as he pleased. She felt it was a violation of his rights for the staff to go through his belongings every time he would return from an outing. She stated she was aware there were several residents that probably had lighters before the fire because they were not consistently going through the smoker's belongings or monitoring what they were getting in packages from family or for themselves. The administrator stated there were several lighters confiscated after the fire, and the new smoking rules were reviewed with each smoker. When asked by the SA if they had removed all the lighters from the current smokers, she stated, she hoped so, but they did not go through every drawer, and closet. They took what they were able to find, and what the residents gave to them. She again stated, several of them went out on pass as their own RR and they were not searched when they came back.

During an interview on 3/8/21, at 11:00 AM, multiple areas of contradiction on the "Smoking Safety Evaluation" form which had been completed on 2/21/21, at 11:00 PM, was reviewed with the Administrator. She agreed the evaluation was not accurately completed and contradictory to itself in several places. She feels it was done hurriedly and attention was not paid to the details on the form.

On 03-08-2021 at 2:00 PM, the SA received a "Discharge Report", dated 02-28-2021, from the

secured, and scheduled smoking times begin starting at 9:00 am. On 03/08/21 beginning at approximately 7:00 PM Staff Development Coordinator (SDC) initiated education with staff, including Certified Nursing Assistants, licensed nurses, housekeeping staff, business office staff, therapy staff, dietary staff, and administrative staff on new smoking policy revisions. No staff will be allowed to return to work without completing. On 03/09/21 at 9:15AM education begin on new smoking policy revision with current smoking residents and smoking materials removed from current smoking resident's possession to include lighters, and cigarettes, on 03/09/21 at 8:30AM keypad locked entry located at designated smoking area on lower first floor activated to ensure supervised access followed. On 03/09/21 at 10:15 AM Resident Council Meeting Held with Activities Director, Resident Council President, and fifteen (15) resident members present to discuss new smoking policy revisions with supervised smoking times, and changes in facility storage of smoking materials. Facility is alleging that all activities to remove the Immediate Jeopardy were completed as of 03/09/21, and the Immediate Jeopardy was removed 03/10/21.

2. On 03/08/21 facility Administrator initiated automated phone reporting system with updated alert including facility storage of all smoking materials and assigned smoking times to alert all current Residents families and facility staff as listed in medical charting or facility payroll

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F 835	Continued From page 41 hospital which revealed, he was taken to surgery for a second time for excision of devitalized tissue and had skin grafts placed. After surgery he was alert and responsive however he was having hypertensive episodes. Laboratory (Lab) staff went in during the night to obtain blood work and he was found unresponsive with no vital signs deceased in the bed. He was a Do Not Resuscitate (DNR). Resident #2 Review of Resident #2's nurses notes, (see below) revealed multiple times in which she had exhibited behaviors such as the use of foul language, false accusations against staff, refusal to be educated on the new smoking policies, and refusal of all medications except for her pain pill. Review of NN, dated 02-11-2021 at 11:00 AM, revealed, "Resident refuses to allow SW (social worker) in her room to receive education on smoking policy, rules and guidelines ..." Review of Resident #2's Care Plan for smoking stated, "(Formal Name) is a smoker. She has been educated on the new smoking policy and has been deemed safe to smoke unsupervised. On 10-01-2018, - resident was observed with burn marks to her fingers. She states that the burns did not come from smoking cigarettes. Resident refused to smoke while supervised. 10-14-2019 - Resident uses vapor cigarettes. 02-22-21 - chooses not to do BIMS assessment." Resident #2's dated 02 Smoking Safety	F 835	system. One hundred and Thirty-one (131) Residents had potential to be affected. 3. On 03/09/21 education begin by Social Services Director and/or Social Services assistant with all current smoking Residents on new smoking policy revisions to include supervised smoking times and facility storage of smoking materials. On 03/09/21 keypad locked entry located at designated smoking area on lower first floor activated by Maintenance Director to ensure supervised access. Smoking evaluations have been changed to under the direction of Social Services for completion and full review of smoking requirements and safety needs upon admission, quarterly, and with any significant changes. 4. Beginning on 03/09/21 the Administrator will monitor all initial admits for timely completion and accuracy weekly for four weeks and then select five Residents' admissions monthly for three months for compliance with supervised smoking and facility storage by facility policy. A report was be submitted on 3/17/21 to the Quality Assurance Performance Improvement for review and recommendations and will continue monthly for three months. The DON is responsible for monitoring and compliance.	

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Evaluation dated 02-23-2021, at 10:11 AM, revealed, her manual dexterity is weak, and her grasp is weak, she drops items, her reflexes are diminished in response, she has upper and lower body limitations, she smokes only in designated areas, and cannot safely light her smoking material, she cannot safely hold her smoking material, she can dispose of her ashes, and can quickly respond to fallen ashes, she follows the smoking guidelines per policy, and returns her smoking materials to storage. There is a note on the evaluation which states, "if one response is answered "NO" then resident should be supervised while smoking" She has 3 "NO"s on her form and yet under the "Summary of Evaluation" it stated she can smoke "unsupervised". In the "Comments" section it stated, "resident has upper and lower body impairments, she requires assistance with lighting cigarettes, resident is able to grasp cigarette but r/t upper body impairments, she is at risk for dropping items."

On 03-05-2021, at 11:30 AM, the SA was asked to visit Resident #2, at her request. While meeting with her, an E-cigarette was observed on her bedside table with two battery cartridges. When asked if she was allowed to smoke in her room, she stated, "Hell Yeah, because that is not a real cigarette anyway, I ain't no harm to no body".

On 03-05-2021, at 1:45 PM., during an interview with R.N.#1, she verified Resident #2 was allowed to smoke her E-cigarette unsupervised in her room because she refused to get out of the bed to go smoke and she refused to be supervised while she was smoking. She stated the management was aware and let her do it.

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F 835	Continued From page 43	F 835		

During an interview on 3/8/21, at 11:00 AM, multiple areas of contradiction on the "Smoking Safety Evaluation" form which had been completed on 2/21/21, at 11 PM, was reviewed with the Administrator. She agreed the evaluation was not accurately completed and contradictory to itself in several places. She feels it was done hurriedly and attention was not paid to the details on the form. She stated she was aware Resident #2 refused to get out of bed to go smoke and smoked her E-cigarette unsupervised in her room all the time. She stated she "needed to be given a 30-day discharge because she had refused to abide by the rules since her admission."

The facility submitted an acceptable Removal Plan on 03-09-2021, at 4:40 PM, in which the facility alleged all corrective actions to remove the IJ were completed on 03-09-2021 and the IJ was removed on 03-10-2021.

Removal Plan:

Brief Summary of Events

On 2/21/21 at 3:06 PM Licensed Practical Nurse (LPN) #1 reported hearing fire alarm sounding. She reported grabbing fire extinguisher and seeing smoke coming out of Resident #1 room. LPN #1 reported calling Residents #1 name and he hollered back help. LPN #1 reported entering room with fire extinguisher, described as thick black smoke with water present, no active fire. LPN #1 did not use fire extinguisher. LPN #1 reported unable to see through the smoke and then RN (Registered Nurse) #1 and CNA (Certified Nursing Assistant) #1 went into Resident #1's room noting a smoke-filled room

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	255146	A. BUILDING _____ B. WING _____	C 03/11/2021

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YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

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with no fire, sprinkler system actively pouring water, and found Resident #1 located lying on floor near foot of bed with no active fire. RN (Registered Nurse) #1 and CNA (Certified Nursing Assistant) #1 along with Dietary Aide #1 transferred Resident #1 from floor to wheelchair and removed Resident #1 from the room. Resident #1 denied pain and reported he lit a cigarette while wearing oxygen. Resident #1 refused to answer on where he obtained lighter from.

Facility failed to provide adequate supervision ensuring Residents were abiding by established smoking rules/policy regarding smoking materials resulting in Resident #1 obtaining lighter and lighting a cigarette lying in bed with oxygen causing fire in the facility that resulted in burns to right shoulder, chest and back. Resident #2 failing to abide by facility policy with possession of electronic cigarette.

Corrective Actions
1. On 2/21/21 at 3:06 pm Receptionist #1 called 911 while facility alarm was sounding. Alarm company also contacted fire department.

2. On 02/21/21 at 3:12 pm Fire department dispatched EnRoute to facility and arrived at 3:14 pm. Sprinkler system was actively spraying water causing excessive smoke. Sprinkler system extinguished the fire prior to arrival of Fire Department. On 02/21/21 at 3:15 pm LPN #2 called 911 requested ambulance.

3. On 02/21/21 at 3: 12 PM Resident #1 was assessed by RN (Registered Nurse) #1. Resident #1 had burns to right front and rear shoulder,

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Right Scapula, and Right side of chest. Ambulance Service arrived at facility at 4:06 PM and begin further evaluation of Resident and transferred to burn center. The facility has no outside legal representative for Resident #1. Resident #1 is his own responsible party. The facility initiated an investigation.

4. On 02/21/21 at 3:15 PM Remaining twenty-three (23) Residents in fire door area begin being escorted to outside parking lot to account for and ensure safety.

5. On 2/21/21 at 4:40 PM Nurse Practitioner (NP)#1 assessed a total of twenty-three (23) Residents which previously resided in affected area. No concerns identified. On 02/24/21 Psychiatric Nurse Practitioner (NP) assessed a total of twenty-three (23) Residents for any emotional distress or trauma as related to the fire with no abnormalities noted. Staff Support hotline posted to provide grief or mental health support due to fire.

6. On 02/21/21 at 5:02 PM Mississippi State Department of Health was notified of event.

7. On 02/21/21 at 6:30 PM Fire Marshall assessed building for any safety issues regarding the fire and cleared the remaining unaffected area to allow occupancy.

8. On 02/21/21 at 6:30 PM Resident rooms involved in evacuation area were assessed for water damage by outside contractor and Residents were actively being relocated to other areas of the building by facility staff. Relocation of twenty-three (23) Residents were completed by 10:30 PM. From 6:30 PM to 10:30 PM

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Responsible Parties of Residents residing in facility were contacted regarding event and safety of Residents by administration staff.

9. On 02/21/21 beginning at approximately 8:00 PM Administrator, Director of Nurses (DON), and Staff Development Coordinator (SDC) initiated education with staff, including Certified Nursing Assistants, licensed nurses, housekeeping staff, business office staff, therapy staff, dietary staff and administrative staff on Abuse and Neglect Prohibition Policy, Resident Rights, Emergency Operations Plan, Fire Evacuation, Smoking Evaluations, and Resident Safety regarding fire. No staff will be allowed to return to work without completing.

10. On 02/22/21 at 5:00 PM, facility Administrator initiated automated phone reporting system alert to Resident families and staff to inform smoking safety including facility storage of lighters, asking families not to purchase flammable materials including new revisions to policy with removal of lighters regardless of smoking safety status. On 03/08/21 at 8:40 PM facility Administrator initiated automated phone reporting system with updated alert including revisions on smoking policy with facility storage of all smoking materials and assigned smoking times. This system automatically sends alerts and contacts families and staff listed in Resident's record and payroll system.

11. On 02/23/21 at 4:30 PM, the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing (Infection Preventionist) , Nurse Practitioner, and Clinical Corporate Consultant held Quality Assurance Performance Improvement meeting to include

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immediate corrective actions following facility fire involving audits on facilities current smoking Residents with room checks, smoking evaluations, smoking safety equipment, room change notifications, updated Brief Interview Mental Status (BIMS), and care plan reviews. Smoking policy was discussed with revision to remove wording that residents may retain their lighters if deemed safe. Resident's room checks were initiated on 2/21/21 with smoking residents to remove all lighters. Room checks were completed on 2/22/21 with multiple lighters found.

12. On 03/08/21 at 6:45 PM, the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing and Clinical Corporate Consultant held Quality Assurance Performance Improvement meeting following notification of Immediate Jeopardy to review steps initiated to prevent any further reoccurrence including new policy and procedure changes. The smoking policy was revised to include supervised smoking of all Residents, assigned smoking times, and facility storage of all smoking material.

13. On 02/24/21 at 11:01 AM final written investigation was sent to Mississippi Department of Health along with Mississippi State Attorney General at 4:55 PM.

14. On 03/03/21 at 11:00 AM Mississippi State Department of Health Life Safety Surveyor entered facility to assess affected area with no negative findings.

15. On 03/08/21 at 3:45 pm E-cigarettes and smoking materials removed from Resident #2 possession, Assistant Director of Nurses (ADON) and Social Service Director (SSD) attempted

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education on new smoking policy and Resident #2 declined education. At 6:00 PM Smoking evaluation completed by Director of Nurses (DON) on Resident #2 revised to indicate Supervised smoking in designated smoking area during assigned smoking times. On 3/9/21 100% room checks of all one hundred and thirty-one (131) resident's room were initiated to remove all smoking materials. No lighters were found. Two electronic cigarettes were removed to include Resident #2. There are no Residents with possession of smoking materials completed on 3/9/21 at 9:00 am.

16. On 03/08/21 at 6:00 PM Director of Nursing (DON) initiated new smoking evaluations on residents along with care plan updates on resident that smoke reflecting safety needs and policy changes. One hundred and Thirty-one (131) Resident smoking evaluations were completed with Twenty-one (21) Resident smoking care plans adjusted. On 3/9/21 at 7:30 am door to smoking area was secured, and scheduled smoking times begin starting at 9:00 am.

17. On 03/08/21 beginning at approximately 7:00 PM Staff Development Coordinator (SDC) initiated education with staff, including Certified Nursing Assistants, licensed nurses, housekeeping staff, business office staff, therapy staff, dietary staff, and administrative staff on new smoking policy revisions. No staff will be allowed to return to work without completing.

18. On 03/09//21 at 9:15 AM education begin on new smoking policy revision with current smoking residents and smoking materials removed from current smoking resident's possession to include

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lighters, and cigarettes, on 03/09/21 at 8:30 AM keypad locked entry located at designated smoking area on lower first floor activated to ensure supervised access followed.

19. On 03/09/21 at 10:15 AM Resident Council Meeting Held with Activities Director, Resident Council President, and fifteen (15) resident members present to discuss new smoking policy revisions with supervised smoking times, and changes in facility storage of smoking materials.

20. Facility is alleging that all activities to remove the Immediate Jeopardy were completed as of 03/09/21, and the Immediate Jeopardy was removed 03/10/21.

Validation of Removal Plan:

The SA validated the Removal Plan on 03-11-2021, and determined the IJ was removed on 03-10-2021, prior to exit. Therefore, the scope and severity for 42 CFR(s): §483.70 -Administration (F835) was lowered from an "L" to an "F", while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory compliance.

1. On 2/21/21 at 3:06 PM Receptionist #1 called 911 while facility alarm was sounding. Alarm company also contacted fire department.
- Verified by the SA via review of the call log and interview.

2. On 02/21/21 at 3:12 pm Fire department dispatched EnRoute to facility and arrived at 3:14 pm. Sprinkler system was actively spraying water causing excessive smoke. Sprinkler system

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extinguished the fire prior to arrival of Fire Department. On 02/21/21 at 3:15 PM LPN #2 called 911 requested ambulance.
- Verified by the SA via review of the Fire Departments call log journal and report.

3. On 02/21/21 at 3: 12 PM Resident #1 was assessed by RN (Registered Nurse) #1. Resident #1 had burns to right front and rear shoulder, Right Scapula, and Right side of chest. Ambulance Service arrived at facility at 4:06 PM and begin further evaluation of Resident and transferred to burn center. The facility has no outside legal representative for Resident #1. Resident #1 is his own responsible party. The facility initiated an investigation.
- Verified by the SA through review of Resident #1's medical record.

4. On 02/21/21 at 3:15 PM Remaining twenty-three (23) Residents in fire door area begin being escorted to outside parking lot to account for and ensure safety.
- Verified by the SA through interview of residents, and review of prior census sheet verses current census sheet of locations.

5. On 2/21/21 at 4:40 PM Nurse Practitioner (NP)#1 assessed a total of twenty-three (23) Residents which previously resided in affected area. No concerns identified. On 02/24/21 Psychiatric Nurse Practitioner (NP) assessed a total of twenty-three (23) Residents for any emotional distress or trauma as related to the fire with no abnormalities noted. Staff Support hotline posted to provide grief or mental health support due to fire.
- Verified by the SA through interview of residents, and review of visit notes in their

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medical records.

6. On 02/21/21 at 5:02 PM Mississippi State Department of Health was notified of event.
- Verified by the SA through review of the report.

7. On 02/21/21 at 6:30 PM Fire Marshall assessed building for any safety issues regarding the fire and cleared the remaining unaffected area to allow occupancy.
- Verified by the SA through review of the Fire Marshall's report, and occupy order.

8. On 02/21/21 at 6:30 PM Resident rooms involved in evacuation area were assessed for water damage by outside contractor and Residents were actively being relocated to other areas of the building by facility staff. Relocation of twenty-three (23) Residents were completed by 10:30 PM. From 6:30 PM to 10:30 PM Responsible Parties of Residents residing in facility were contacted regarding event and safety of Residents by administration staff.
- Verified by the SA through resident interview, as most are their own responsible parties, medical record review and family call log review.

9. On 02/21/21 beginning at approximately 8:00 PM Administrator, Director of Nurses (DON), and Staff Development Coordinator (SDC) initiated education with staff, including Certified Nursing Assistants, licensed nurses, housekeeping staff, business office staff, therapy staff, dietary staff and administrative staff on Abuse and Neglect Prohibition Policy, Resident Rights, Emergency Operations Plan, Fire Evacuation, Smoking Evaluations, and Resident Safety regarding fire. No staff will be allowed to return to work without completing.

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F 835	Continued From page 52 - Verified by the SA through sign-in sheet review and staff interviews. 10. On 02/22/21 at 5:00 PM, facility Administrator initiated automated phone reporting system alert to Resident families and staff to inform smoking safety including facility storage of lighters, asking families not to purchase flammable materials including new revisions to policy with removal of lighters regardless of smoking safety status. On 03/08/21 at 8:40 PM facility Administrator initiated automated phone reporting system with updated alert including revisions on smoking policy with facility storage of all smoking materials and assigned smoking times. This system automatically sends alerts and contacts families and staff listed in Resident's record and payroll system. - Verified by the SA through review of the transcript provided by "Voice Friend Reporting" and the call times messages were sent out. 11. On 02/23/21 at 4:30 PM, the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing (Infection Preventionist) , Nurse Practitioner, and Clinical Corporate Consultant held Quality Assurance Performance Improvement meeting to include immediate corrective actions following facility fire involving audits on facilities current smoking Residents with room checks, smoking evaluations, smoking safety equipment, room change notifications, updated Brief Interview Mental Status (BIMS), and care plan reviews. Smoking policy was discussed with revision to remove wording that residents may retain their lighters if deemed safe. Resident's room checks were initiated on 2/21/21 with smoking residents to remove all lighters. Room checks were	F 835		

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completed on 2/22/21 with multiple lighters found.
- Verified by the SA via review of the sign-in sheet, review of the content of the meeting items discussed, and staff interviews.

12. On 03/08/21 at 6:45 PM, the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing and Clinical Corporate Consultant held Quality Assurance Performance Improvement meeting following notification of Immediate Jeopardy to review steps initiated to prevent any further reoccurrence including new policy and procedure changes. The smoking policy was revised to include supervised smoking of all Residents, assigned smoking times, and facility storage of all smoking material.
- Verified by the SA via review of the sign-in sheet, review of the content of the meeting items discussed, and staff interviews.

13. On 02/24/21 at 11:01 AM final written investigation was sent to Mississippi Department of Health along with Mississippi State Attorney General at 4:55 PM.
- Verified by the SA through review of the report received and a copy of the fax sheet that was timed and dated.

14. On 03/03/21 at 11:00 AM Mississippi State Department of Health Life Safety Surveyor entered facility to assess affected area with no negative findings.
- Verified by the SA through review of the LSC Surveyors report

15. On 03/08/21 at 3:45 pm E-cigarettes and smoking materials removed from Resident #2 possession, Assistant Director of Nurses (ADON) and Social Service Director (SSD) attempted

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education on new smoking policy and Resident #2 declined education. At 6:00 PM Smoking evaluation completed by Director of Nurses (DON) on Resident #2 revised to indicate Supervised smoking in designated smoking area during assigned smoking times. On 3/9/21 100% room checks of all one hundred and thirty-one (131) resident's room were initiated to remove all smoking materials. No lighters were found. Two electronic cigarettes were removed to include Resident #2. There are no Residents with possession of smoking materials completed on 3/9/21 at 9:00 am.
- Verified by SA via resident interview, reviewing new assessments within the medical records against the checklist of current smokers.

16. On 03/08/21 at 6:00 PM Director of Nursing (DON) initiated new smoking evaluations on residents along with care plan updates on resident that smoke reflecting safety needs and policy changes. One hundred and Thirty-one (131) Resident smoking evaluations were completed with Twenty-one (21) Resident smoking care plans adjusted. On 3/9/21 at 7:30 am door to smoking area was secured, and scheduled smoking times begin starting at 9:00 am.
- Verified by the SA through review of the new smoking assessments dated for 03-08-2021 in the medical records of all residents currently in the building.

17. On 03/08/21 beginning at approximately 7:00 PM Staff Development Coordinator (SDC) initiated education with staff, including Certified Nursing Assistants, licensed nurses, housekeeping staff, business office staff, therapy staff, dietary staff, and administrative staff on new

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F 835	Continued From page 55 smoking policy revisions. No staff will be allowed to return to work without completing. - Verified by the state agency through review of the sign-in sheet and staff interviews. 18. On 03/09//21 at 9:15 AM education begin on new smoking policy revision with current smoking residents and smoking materials removed from current smoking resident's possession to include lighters, and cigarettes, on 03/09/21 at 8:30 AM keypad locked entry located at designated smoking area on lower first floor activated to ensure supervised access followed. - Verified by the SA through interviews with the residents who smoke and the new code pad installed next to the door with numeric code entry to unlock it. 19. On 03/09/21 at 10:15 AM Resident Council Meeting Held with Activities Director, Resident Council President, and fifteen (15) resident members present to discuss new smoking policy revisions with supervised smoking times, and changes in facility storage of smoking materials. - Verified by the SA through review of the council sign-in form, and resident interview regarding topics discussed and understanding. 20. Facility is alleging that all activities to remove the Immediate Jeopardy were completed as of 03/09/21, and the Immediate Jeopardy was removed 03/10/21. - The SA verified all aspects of the Removal Plan had been carried out as stated, and the Immediate Jeopardy was removed on 03-10-2021, as stated.	F 835		
F 921 SS=F	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i)	F 921		4/9/21

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F 921	Continued From page 56 §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews and facility policy review, the facility failed to provide a safe, sanitary, and comfortable environment for residents on three (3) of three (3) units observed. Findings include: Review of the facility's policy titled, "Contaminated Isolation Room Cleaning", revised on 05-01-2005, revealed: "Steps to do Job:...scrub hands...remove all trash...spray trash containers inside and out, dry and reline...spray high touch areas and walls and dry them...disinfect the bathroom using the 7-step "Healthcare wash-room cleaning method" (fill dispensers, pull trash, sweep the floor, spray the mirror/sink area and dry, spray the toilet are and shower stall and dry, and wet mop the floor), wet mop the room floor. Normal cleaning of patient room except worker must gown up..." On 03-09-2021, at 12:30 PM, during an interview with the Housekeeping Supervisor, he stated the policy he gave me for the contaminated room clean was the same as the regular room cleaning except for the use of the full personal protective equipment. On 03-03-2021, at 6:45 PM, during an initial tour of the facility with the Assistance Director of	F 921	1. Beginning on 3/9/21, all resident□s rooms were deep cleaned, trash cans either cleaned or replaced, and walls scrubbed. This was completed on 3/12/21. On 3/9/21, Exterminator sprayed all public areas, resident□s rooms, and kitchen. No roaches were found by exterminator at that time. On, 3/9/21 ceiling tile was replaced in hallway near emergency exit on 200 hall. 2. Job routines for contact cleaning company were assessed and adjusted based on the needs of the facility. Seventy (70) hours were permanently added to cleaning schedule to include a new evening housekeeper position. This has the potential to affect all residents. 3. Beginning on 3/9/21 education was initiated by the District Manager with all housekeeping staff to include proper cleaning requirements for resident's rooms, high traffic areas, and COVID cleaning. 4. Beginning on 3/10/21, the Housekeeping Manger will inspect five rooms per day for seven days, ten rooms per week for four weeks, and then fifteen rooms monthly for three months. A report was be submitted on 3/17/21 to the Quality Assurance Performance Improvement for review and recommendations and will continue	

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F 921	Continued From page 57 Nursing (ADON), the entrance to the facility's trash was full and overflowing, and paper debris littering the entrance. The main dining room floors were covered in spilled fluids off meal carts and left until dried. Main walkways of 100 Hall, 200 Hall and 300 Hall, needed to be swept, straw paper coverings, and alcohol pad papers were strewn on hallway floors. The floor behind nurses stations needed to be swept and trash containers emptied. Rooms near the smoking exit door on the 100 Hall have black shoe prints on the room floors, slightly sticky to walk on. Room 132 has a large bag of cat food in the closet that is spilled all on the floor and there are large cockroaches crawling on the food. Large cockroaches were also noted in the entry way of the smoker's area. Observations made were shared with the ADON, and she agreed this was normal for the facility, and needed to be cleaned up. Observations made during facility tour on 03-04-21 at 9:10 AM: Room 128 - Trash was not emptied and overflowed into the room, and the floor had not been swept or mopped, with food debris from multiple meals on the floor. Black shoe prints were noted all over the room floor and tracked into the restroom. A yellow substance was dried on the floor around the toilet, with a strong ammonia smell in the restroom. Brown and gray colored debris was caked around the toilet and all the door jams to the restroom, the closet, and the resident room. Room 132 - The room floor needed to be mopped, and the restroom floor was covered in a dried brown, odiferous substance. The walls under the sink were covered with ill fitting,	F 921	monthly for three months. The Administrator is responsible for monitoring and compliance.	

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mismatched boards that had been tacked up to cover a large hole. The bottoms of the trash cans were covered in dried brown and red liquids.

Room 134 - Food was all over the floor, and bed "B's" fall mat was covered in stains of all colors and sizes. The trash cans had no trash bags in them, and the inside of the can was caked with gum and a brown odiferous substance. The walls behind the beds were gauged/chipped and the bedside tables were all sticky with dried liquids. The corners of the room floor and the doorjambs were caked with brown and gray debris and the door was hard to close due to the build up around the door frame.

Room 135 - The restroom floor was covered in black shoe prints all around the toilet. The privacy curtain between the resident beds were dirty and covered in brown and red stains of all shapes and sizes.

Room 222 - A large amount of food debris was noted all over the floor in front of the bed, and the bedside table was sticky. The toilet and floor in the restroom were covered in a dried, yellow substance with a strong ammonia smell to it and there were shoe prints through the yellow substance and all over the floor in the room.

Room 226 - The corner, behind the air conditioner, was crusted with debris and the floor needed to be swept and mopped due to syringe caps and empty alcohol pad papers remaining all over the floor. There were no trash bags in the trash cans. Observation revealed a brown/black banana peel, gloves, and used tissues in the bottom of the trash can. The restroom floor was caked on the edges with brown and gray debris,

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and the linoleum was torn in front of the toilet, creating a potential trip hazard. The trash can in the restroom was overflowing. Brown and gray debris was also caked around the toilet base and the doorframes of the room.

Room 233 - The floor near the beds were covered with food debris, candy wrappers and paper pieces. The floor needed to be mopped, and the trash can had no bag in it with debris dried in the bottom of the can. The bathroom floor was dirty, covered in tracks from wheelchairs and there was a build up around the toilet and doorway of brown/gray debris.

Room 235 - The floor was tacky all over it, causing the SA shoes to stick to the floor, especially next to the beds. The toilet was covered in a dried, yellow substance that smells of ammonia strongly. There were shoe prints throughout the room and restroom. There were no bags in the trash cans, with brown dried substance in the bottom of the trash can. Brown/gray debris was caked around the toilet base, and the privacy curtains in the room were stained with brown stains of all shapes and sizes.

Cockroaches were noted in the light fixture of the "Garden Room" outside the 100 Hall Dining Room.

Observations made during facility tour on 03-05-21 at 9:00 AM:

Room 207 - The floor was covered in mud/dirt, and the privacy curtain between the resident's beds was dirty with stains of various colors and sizes on it.

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Room 301 - D - A brown substance was sprayed all over the wall under the light cord, and on the ceiling. There was a large hole approximately the size of a softball, in the wall on the side of the closet.

The ceiling in front of the emergency exit, on the 2nd floor, is brown and bowing from water damage.

During an interview on 03-09-2021 at 12:30 PM, with the Housekeeping Supervisor, he stated staffing, for him, had been a challenge at times. He is minimally staffed, so when there was a call off, they were critically short. He feels his current staff are working hard throughout their shift, they are just not able to get it done and done well. He stated his Corporate Director had agreed, during the survey, to increase his floor staff by one person for the "high traffic areas". When asked by the SA if that change was going to continue after the survey, he stated, "I sure hope so, because we need it."

During an interview on 03-09-2021, at 1:00 PM, with the Administrator, she stated the issue with housekeeping and the dirty environment was not due to her Housekeeping Supervisor or the staff he had employed. She felt it had a direct correlation with the fact the services were contracted, and not in-house based. She felt there was little buy in from them, and they always cut staffing to a bare minimum. They were given 4 housekeepers during the day to clean 180 rooms, the hallways, and all the dining and living rooms. It simply was not enough. She stated she was going to have a meeting with the hired company and demand more help keeping the

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F 921	Continued From page 61 facility clean and homelike for the residents, because the current levels were unacceptable.	F 921		
F 926 SS=L	Smoking Policies CFR(s): 483.90(i)(5) §483.90(i)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account nonsmoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interviews, staff interviews, and facility policy review, the facility failed to adhere to the smoking policy to ensure resident's safety while smoking for 20 of 20 smokers out of a total of 133 residents, with a sample of seven (7), Residents #1, #2, #3, #4, #5, #6 and #7. The facility's failure to follow the smoking policy placed residents at risk, and in a situation, which caused serious injury and death for one (1) resident, Resident #1, and was likely to cause serious injury, harm, impairment, or death for others. The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 02-21-2021, when the facility's failure to follow the smoking policy by providing supervision of residents while smoking, ensuring they were not smoking in the presence of oxygen or combustible chemicals, and ensuring the removal of lighters and combustible materials from residents rooms, resulted in a resident smoking in his bed, with his oxygen on, causing a fire in the facility giving him third degree burns to his right	F 926	. On 03/8/21 at 2:20PM State Agency (SA) notified facility department heads to include Administrator of Immediate Jeopardy (IJ) with substandard quality of care related to accidents/supervision, Administration and Smoking policies. Facility failed to provide adequate supervision ensuring Residents were abiding by established smoking rules/policy regarding smoking materials resulting in Resident #1 obtaining lighter and lighting a cigarette lying in bed with oxygen causing fire in the facility that resulted in burns to right shoulder, chest and back. Resident #2 failing to abide by facility policy with possession of electronic cigarettes. On 2/21/21 at 3:06 pm Receptionist #1 called 911 while facility alarm was sounding. Alarm company also contacted fire department. On 02/21/21 at 3:12pm Fire department dispatched In route to facility and arrived at 3:14pm. Sprinkler system was actively spraying water causing excessive smoke. Sprinkler system extinguished the fire prior to arrival of Fire Department. On 02/21/21 at	4/9/21

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F 926	Continued From page 62 shoulder, right front chest, and right upper back which required extensive skin grafts. He also suffered from inhalation burns, which later contributed to his demise. The facility had to relocate 23 residents to alternate beds within the facility who incurred loss of personal property, and the loss of 32 beds within the facility to water damage. On 03-08-2021, at 2:00 PM, the State Agency (SA) informed the Nursing Home Administrator (NHA) of the Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) and provided the Administrator with the IJ Template. IJ existed at: 42 CFR §483.90(i)(5) - Smoking Policies (F926) - Scope and Severity - "L" The facility submitted a credible Removal Plan on 03-09-2021, at 4:40 PM, in which the facility alleged all corrective actions to remove the IJ were completed and the IJ removed as of 03-10-2021. The SA validated the Removal Plan on 03-11-2021 and determined the IJ was removed prior to exit. Therefore, the scope and severity for IJ existed at: 42 CFR §483.90(i)(5) - Smoking Policies (F926) was lowered from an "L" level of scope and severity to an "F" while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include:	F 926	3:15 pm LPN #2 called 911 requested ambulance. On 02/21/21 at 3: 12PM Resident #1 was assessed by RN (Registered Nurse) #1. Resident #1 had burns to right front and rear shoulder, Right Scapula, and Right side of chest. Ambulance Service arrived at facility at 4:06PM and begin further evaluation of Resident and transferred to burn center. The facility has no outside legal representative for Resident #1. Resident #1 is his own responsible party. The facility initiated an investigation. On 02/21/21 at 3:15 PM Remaining twenty-three (23) Residents in fire door area begin being escorted to outside parking lot to account for and ensure safety. On 2/21/21 at 4:40 PM Nurse Practitioner (NP)#1 assessed a total of twenty-three (23) Residents which previously resided in affected area. No concerns identified. On 02/24/21 Psychiatric Nurse Practitioner (NP) assessed a total of twenty-three (23) Residents for any emotional distress or trauma as related to the fire with no abnormalities noted. Staff Support hotline posted to provide grief or mental health support due to fire. On 02/21/21 at 5:02 PM Mississippi State Department of Health was notified of event. On 02/21/21 at 6:30 PM Fire Marshall assessed building for any safety issues regarding the fire and cleared the remaining unaffected area to allow occupancy. On 02/21/21 at 6:30 PM Resident rooms involved in evacuation area were assessed for water damage by outside contractor and Residents were actively	

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Review of the facility's policy titled, "Resident Acknowledgement - Facility Smoking Policy" revised on 08-11-2020 revealed:
"Safe Smoking Environment: It is the responsibility of the facility to provide a safe and hazard free environment for those residents having been assessed as safe for facility smoking privileges. The Oxygen cylinders will not be permitted in any authorized smoking area. Facility smoking policies through verbal means, distribution and posting. This policy is intended to minimize the risks to: Residents who smoke, including possible adverse effects on treatment, passive smoke to others, and fire.
Smoking Accommodation: This policy does not include chewing tobacco. Residents may maintain their own tobacco supplies in their room and do not have to be supervised. E-Cigarettes will be treated like cigarettes per policy. At no time will E-Cigarettes be permitted for use inside of the facility. The smoking of marijuana is prohibited in a Nexion Facility. The facility is responsible for enforcement of smoking policies. Smoking is prohibited in any room, ward, or compartment within the facility with exception being the designated smoking room on the first floor. Smoking is prohibited where flammable liquids, combustible gas or oxygen are stored, and in any other hazardous location. These areas are posted with "nonsmoking area" signs. Residents wishing to smoke while at the facility will have a "Smoking Safety Evaluation" completed by the interdisciplinary team to determine the resident's ability to follow smoking policies safely. All residents who wish to smoke must provide funds to purchase their own smoking paraphernalia. Oxygen carrying devices will not be permitted in any authorized smoking area.

being relocated to other areas of the building by facility staff. Relocation of twenty-three (23) Residents were completed by 10:30PM. From 6:30 PM to 10:30 PM Responsible Parties of Residents residing in facility were contacted regarding event and safety of Residents by administration staff. On 02/21/21 beginning at approximately 8:00 PM Administrator, Director of Nurses (DON), and Staff Development Coordinator (SDC) initiated education with staff, including Certified Nursing Assistants, licensed nurses, housekeeping staff, business office staff, therapy staff, dietary staff and administrative staff on Abuse and Neglect Prohibition Policy, Resident Rights, Emergency Operations Plan, Fire Evacuation, Smoking Evaluations, and Resident Safety regarding fire. No staff will be allowed to return to work without completing. On 02/22/21 at 5:00PM, facility Administrator initiated automated phone reporting system alert to Resident families and staff to inform smoking safety including facility storage of lighters, asking families not to purchase flammable materials including new revisions to policy with removal of lighters regardless of smoking safety status. On 03/08/21 at 8:40PM facility Administrator initiated automated phone reporting system with updated alert including revisions on smoking policy with facility storage of all smoking materials and assigned smoking times. This system automatically sends alerts and contacts families and staff listed in Resident□s record and payroll

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F 926	Continued From page 64 Check Option that applies to facility: 1. All smoking in this facility is SUPERVISED and at designated times. Staff will maintain/keep all smoking materials (e.g., cigarettes, pipes, matches, lighters, lighter fluid) and distribute the materials to residents at smoking times. 2. Residents who are deemed "safe" will be allowed to smoke unsupervised and may be permitted to keep cigarettes on their persons. If resident is deemed "unsafe", they will be required to surrender all smoking paraphernalia to facility. Staff will maintain/keep all smoking materials (e.g., cigarettes, E-Cigarettes, pipes, matches, lighters, lighter fluid) and distribute the materials to residents at smoking times. Furthermore, a smoking schedule will be posted, and resident will be required to smoke with supervision only, according to schedule. Smoking Infraction: The first infraction of the smoking policy results in a warning. This warning may be verbal. The warning is given to both the resident and their family member of contact. A safe smoking reassessment of that resident is performed to determine supervision required. The second infraction of the smoking policy may result in notice of discharge. The reason for discharge would be endangerment to the health and safety of residents." On 03-03-2021, at 7:20 PM, during an interview with the administrator she stated Resident #1, the resident who started the facility fire, was his own Resident Representative (RR). His Brief Interview of Mental Status (BIMS) score was 15 deeming him able to make his own decisions. He left the facility three (3) times a week for dialysis and would come and go as he pleased. She felt it was a violation of his rights for the staff to go through his belongings every time he would return from	F 926	system. On 02/23/21 at 4:30 PM, the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing (Infection Preventionist) , Nurse Practitioner, and Clinical Corporate Consultant held Quality Assurance Performance Improvement meeting to include immediate corrective actions following facility fire involving audits on facilities current smoking Residents with room checks, smoking evaluations, smoking safety equipment, room change notifications, updated Brief Interview Mental Status (BIMS), and care plan reviews. Smoking policy was discussed with revision to remove wording that residents may retain their lighters if deemed safe. Resident□s room checks were initiated on 2/21/21 with smoking residents to remove all lighters. Room checks were completed on 2/22/21 with multiple lighters found. On 03/08/21 at 6:45 PM, the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing and Clinical Corporate Consultant held Quality Assurance Performance Improvement meeting following notification of Immediate Jeopardy to review steps initiated to prevent any further reoccurrence including new policy and procedure changes. The smoking policy was revised to include supervised smoking of all Residents, assigned smoking times, and facility storage of all smoking material. On 02/24/21 at 11:01 AM final written investigation was sent to Mississippi Department of Health along with Mississippi State Attorney General at	

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an outing. She stated she was aware there were several residents that probably had lighters before the fire because they were not consistently going through the smoker's belongings or monitoring what they were getting in packages from family or for themselves. The administrator stated there were several lighters confiscated after the fire, and the new smoking rules were reviewed with each smoker. When asked by the SA if they had removed all the lighters from the current smokers, she stated, she hoped so, but they did not go through every drawer, and closet. They took what they were able to find, and what the residents gave to them. She again stated, several of them went out on pass as their own RR and they were not searched when they came back. She stated they had hired staff to do supervised smoking from 8:00 AM - 10:00 PM.

Resident #1

The facility's smoking policy also stated, " All smoking in this facility is SUPERVISED and at designated times. Staff will maintain/keep all smoking materials (e.g. cigarettes, pipes, matches, lighters, lighter fluid and distribute the materials to residents at smoking times...Furthermore, a smoking schedule will be posted and residents will be required to smoke with supervision only, according to schedule."

A Smoking Safety Evaluation dated 02-20-21 at 9:00 PM stated he was identified as a safe smoker.

Record review of a NN dated 02-21-21, at 5:31 PM, titled "Incident Note" stated the "Fire alarm was automatically activated, heavy dark smoke

4:55 PM. On 03/03/21 at 11:00AM Mississippi State Department of Health Life Safety Surveyor entered facility to assess affected area with no negative findings. On 03/08/21 at 3:45pm E-cigarettes and smoking materials removed from Resident #2 possession, Assistant Director of Nurses (ADON) and Social Service Director (SSD) attempted education on new smoking policy and Resident #2 declined education. At 6:00 PM Smoking evaluation completed by Director of Nurses (DON) on Resident #2 revised to indicate Supervised smoking in designated smoking area during assigned smoking times. On 3/9/21 100% room checks of all one hundred and thirty-one (131) resident□s room were initiated to remove all smoking materials. No lighters were found. Two electronic cigarettes were removed to include Resident #2. There are no Residents with possession of smoking materials completed on 3/9/21 at 9:00 am. On 03/08/21 at 6:00PM Director of Nursing (DON) initiated new smoking evaluations on residents along with care plan updates on resident that smoke reflecting safety needs and policy changes. One hundred and Thirty-one (131) Resident smoking evaluations were completed with Twenty-one (21) Resident smoking care plans adjusted. On 3/9/21 at 7:30 am door to smoking area was secured, and scheduled smoking times begin starting at 9:00 am. On 03/08/21 beginning at approximately 7:00 PM Staff Development Coordinator (SDC) initiated education with staff, including Certified Nursing Assistants, licensed nurses,

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and copious amounts of water was noted coming from room 102 D. Resident noted in the room lying on the floor by the foot of the bed calling out "help me". Res. was transferred to wheelchair then to safety by staff. Burns were noted on the resident's upper right chest, right arm, and upper right back. Resident stated he had a cigarette lighter to light his cigarette but did not reveal where he got the lighter."

An additional Smoking Safety Evaluation was completed on 02-21-21 at 11:00 PM, after Resident #1 had been admitted to the hospital, that indicated his mental status was alert, decision ability was consistent, his reflexes were quick response, he did NOT only smoke in designated areas, he could safely light and hold a cigarette, he responds quickly to fallen ashes, he did NOT follow the smoking guidelines, he returned his smoking materials to storage, he did not remove his oxygen tubing, and could extinguish his own cigarette. The Evaluation further states, "if one response is answered "no" then resident should be supervised while smoking". There were several items marked "no" on the form, yet the "Summary of Evaluation" indicated he was "safe to smoke unsupervised", and the "Comments" stated "Resident has been deemed as an unsafe smoker, he has a BIMS of 15 and chooses to smoke unsafely. Resident smokes while O2 is in use while in the bed."

During an interview on 3/8/21, at 11:00 AM, multiple areas of contradiction on the "Smoking Safety Evaluation" form which had been completed on 2/21/21, at 11:00 PM, was reviewed with the Administrator. She agreed the evaluation was not accurately completed and contradictory to itself in several places. She feels it was done

housekeeping staff, business office staff, therapy staff, dietary staff, and administrative staff on new smoking policy revisions. No staff will be allowed to return to work without completing. On 03/09//21 at 9:15AM education begin on new smoking policy revision with current smoking residents and smoking materials removed from current smoking resident's possession to include lighters, and cigarettes, on 03/09/21 at 8:30AM keypad locked entry located at designated smoking area on lower first floor activated to ensure supervised access followed. On 03/09/21 at 10:15 AM Resident Council Meeting Held with Activities Director, Resident Council President, and fifteen (15) resident members present to discuss new smoking policy revisions with supervised smoking times, and changes in facility storage of smoking materials. Facility is alleging that all activities to remove the Immediate Jeopardy were completed as of 03/09/21, and the Immediate Jeopardy was removed 03/10/21.

2. On 03/08/21 the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Clinical Corporate Consultant reviewed and revised the Smoking policy to include supervised smoking of all Residents, Assigned smoking times, and facility storage of all smoking materials. One hundred and Thirty-one (131) Residents had potential to be affected.

3. On 03/08/21 Staff Development

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F 926	Continued From page 67 hurriedly and attention was not paid to the details on the form. Resident #2 The facility failed to follow the smoking policy in multiple ways to include: The facility's smoking policy revealed, "E-Cigarettes will be treated like cigarettes per policy. At no time will E-Cigarettes be permitted for use inside of the facility." On 03-05-2021, at 11:30 AM, the SA was asked to visit Resident #2, at her request. While meeting with her, an E-cigarette was observed on her bedside table with two battery cartridges. When asked if she was allowed to smoke in her room, she stated, "Hell Yeah, because that is not a real cigarette anyway, I ain't no harm to no body". Record review of her latest MDS dated 12-28-2020, revealed she had a BIMS of 15 and was able to make her own decisions regarding her care, she required total assistance of two (2) staff members for her ADL's, and the use of a mechanical lift for transfers. On 03-05-2021, at 1:45 PM., during an interview with R.N.#1, she verified Resident #2 was allowed to smoke her E-cigarette unsupervised in her room because she refused to get out of the bed to go smoke and she refused to be supervised while she was smoking. She stated the management was aware and let her do it. During an interview on 3/8/21, at 11 AM, multiple areas of contradiction on the "Smoking Safety Evaluation" form which had been completed on 2/21/21, at 11 PM, was reviewed with the Administrator. She agreed the evaluation was	F 926	Coordinator initiated education with staff on new smoking policy revisions including assigned smoking times, supervised smoking of all residents and facility storage of smoking materials. 4.Beginning on 03/09/21 the Social Services will monitor all initial admits for compliance in regard to new supervised smoking policy weekly for four weeks and then select five Residents' admissions monthly for three months for compliance with supervised smoking and facility storage by facility policy. A report was be submitted on 3/17/21 to the Quality Assurance Performance Improvement for review and recommendations and will continue monthly for three months. The DON is responsible for monitoring and compliance.	

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not accurately completed and contradictory to itself in several places. She feels it was done hurriedly and attention was not paid to the details on the form. She stated she was aware Resident #2 refused to get out of bed to go smoke and smoked her E-cigarette unsupervised in her room all the time. She stated she "needed to be given a 30-day discharge because she had refused to abide by the rules since her admission."

Resident #2's dated 02 Smoking Safety Evaluation dated 02-23-2021, at 10:11 AM, revealed, her manual dexterity is weak, and her grasp is weak, she drops items, her reflexes are diminished in response, she has upper and lower body limitations, she smokes only in designated areas, and cannot safely light her smoking material, she cannot safely hold her smoking material, she can dispose of her ashes, and can quickly respond to fallen ashes, she follows the smoking guidelines per policy, and returns her smoking materials to storage. There is a note on the evaluation which states, "if one response is answered "NO" then resident should be supervised while smoking" She has 3 "NO"s on her form and yet under the "Summary of Evaluation" it stated she can smoke "unsupervised". In the "Comments" section it stated, "resident has upper and lower body impairments, she requires assistance with lighting cigarettes, resident is able to grasp cigarette but r/t upper body impairments, she is at risk for dropping items."

Resident #3

On 03-04-2021 at 10:10 AM, during an interview with Resident #3, she stated, " I don't have a lighter no more, since they came and got them a

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week ago. I'll be honest, I don't know if I still got some of them stashed in all those boxes or not. We been moved around so much for the virus and then the fire that all my stuff is in boxes right now. I keep my cigarettes in my purse." The SA observed a pack of cigarettes laying on her bedside table and another one sticking out of one of her clothing drawers.

Record review of Resident #3's last Quarterly MDS dated 12-18-2020 revealed she had a BIMS of 15 and was able to make her own decisions, and required extensive assistance to get dressed every day, and supervision of staff for all others.

During an interview on 03-08-2021 at 11:20 AM with the SSD, she was asked if the date reflected when she removed the lighter from Resident #3, or just the date she entered the intervention, as 03-01-2021 would have been eleven (11) days after the fire this resident had access to a lighter. She stated, "I'm unable to say right now, I don't remember all the dates."

Resident #4

On 03-04-2021 at 10:15 AM, during an interview with Resident #4, she stated, "I keep my cigarettes in my purse next to my bed. I don't have a lighter anymore since the staff came and took them after the fire. Somebody is usually out there from around 8 am - 10 pm, but the weekends are real bad. Last weekend there was nobody here to do the smoking for us all day on Sunday, so we had a staff member light a cigarette for one of us, and then we just tried to light each other's for everybody as they came out the rest of the day. I go out and smoke 10-12 times a day, and there is usually 5-6 times a

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week that no staff member is out there. There is a couple guys that need help smoking, so if they come out there when no staff is there, we try to remember to help put on their aprons and light their cigarettes for them. We try to watch out for each other."

Record review of Resident #4's latest quarterly MDS dated 01-07-2021, revealed a BIMS score of 15, meaning she is able to make her own decisions, and required supervision for all her Activities of Daily Living (ADL's).

Resident #5

On 03-04-2021 at 10:30 AM, during an interview with Resident #5, he stated, "I keep my cigs in my room in that lock drawer over there, but I don't have no lighter anymore. They came and took it after that guy lit the place up. If they find a lighter on you, you get a 30-day notice and I been here for almost 6 years. From 8 AM - 1 PM there is usually a staff member out there with us, but if no one is out there, we light off each other out of respect for the staff, not having to come out here while they are trying to work. (Formal name of another resident) needs help to smoke, cuz his hands shake so bad, so we try to help him when he rolls out without help...I am out here smoking most of the day. I go in to eat and to take a nap."

Record Review of Resident #5's latest quarterly MDS, dated 02-19-2021, revealed a BIMS score of 14, making him able to make his own decisions, and requiring supervision for most of his ADL's, except for putting on his clothing, due to only having one arm.

Resident #6

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F 926	Continued From page 71 On 03-04-2021 at 11:38 AM, during an interview with Resident #6, she stated, "There are several times a week when there ain't no staff out there for us. This past Sunday there was only a staff out there one time, and that is cuz they wanted to smoke. (Formal name of another resident) needs help to smoke and the aides sometimes push him out and put his apron on and then leave, so we light his cigarette for him." Review of Resident #6's latest quarterly MDS, dated 02-18-2021, revealed she has a BIMS of 15, making her able to make her own decisions, and she required supervision for all of her activities of daily living. Resident #7 On 03-04-2021 at 11:20 AM, during an interview with Resident #7, he stated, " I keep my cigarettes in my pocket or my hat, I don't have a lighter anymore since they came and took them from us. I usually go down there about three times a day and if staff are there, they will light our cigarettes. There is usually someone out there until after 10:00 o'clock at night. If not, we will light each other's cigarettes. (Formal name of another resident) is the man that needs help there and he rolls himself outside. His handshakes bad, so I helped him put the cigarette in his mouth and then we light it with our own cigarettes. There don't always be staff out there all the time when we are smoking. We try to make sure he has his apron on, but I'm sure sometimes he does not... We try to lookout for each other out there to make sure everybody is OK."	F 926		

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Review of Resident #7's latest quarterly MDS dated 12-14-2020, revealed he has a BIMS score of 15, making him able to make his own decisions, and he required limited assistance for all of his activities of daily living.

On 03-07-2021 at 11:10 AM, an observation was made of a letter given to all the smokers, posted on the wall next to their beds. The letter said, "Effective 2/15/2021 Yazoo City Rehabilitation and Healthcare Center will go to supervised smoking for all residents. At this time, the facility will take control of all smoking paraphernalia including cigarettes, lighters, tobacco pipes, etc. These will be kept in a lock box in the medication room on the first floor and will be brought out for the smoking times. Smoking times are as follows: 7:30, 8:30, 10:15, 1:00. 3:45, 6:00, 8:00 and 9:30. Each smoking time will be 15 to 20 minutes long depending on the number of smokers. Failure to follow these rules will result in to a thirty-day discharge notice being issued."

On 03-07-2021 at 2:15 PM, during an interview with the Activities Director (AD), she stated there were two people that needed support to smoke. They were to wear aprons at all times. One resident could not hold his own cigarette due to shaking from Parkinson's disease, and the other would often fall asleep when smoking and would drop his cigarette on himself. She stated they had activity staff that stayed outside with the residents from around 8:00 am - 10:00 pm. When asked by the SA what a resident was supposed to do if they wanted to smoke a cigarette at 2:00 AM, she stated they would have to find a staff member willing to light their cigarette for them and sit with those that need to be helped. When asked by the SA about the letter posted beside the beds of all

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the smokers, she stated the facility was not following the letter because of the uproar the residents made regarding locking up their cigarettes, and not being able to smoke whenever they wanted to, like they are now.

The facility submitted an acceptable Removal Plan on 03-09-2021, at 4:40 PM, in which the facility alleged all corrective actions to remove the IJ were completed on 03-09-2021 and the IJ was removed on 03-10-2021.

Removal Plan
Brief Summary of Events

On 2/21/21 at 3:06 PM Licensed Practical Nurse (LPN) #1 reported hearing fire alarm sounding. She reported grabbing fire extinguisher and seeing smoke coming out of Resident #1 room. LPN #1 reported calling Residents #1 name and he hollered back help. LPN #1 reported entering room with fire extinguisher, described as thick black smoke with water present, no active fire. LPN #1 did not use fire extinguisher. LPN #1 reported unable to see through the smoke and then RN (Registered Nurse) #1 and CNA (Certified Nursing Assistant) #1 went into Resident #1's room noting a smoke-filled room with no fire, sprinkler system actively pouring water, and found Resident #1 located lying on floor near foot of bed with no active fire. RN (Registered Nurse) #1 and CNA (Certified Nursing Assistant) #1 along with Dietary Aide #1 transferred Resident #1 from floor to wheelchair and removed Resident #1 from the room. Resident #1 denied pain and reported he lit a cigarette while wearing oxygen. Resident #1 refused to answer on where he obtained lighter from.

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Facility failed to provide adequate supervision ensuring Residents were abiding by established smoking rules/policy regarding smoking materials resulting in Resident #1 obtaining lighter and lighting a cigarette lying in bed with oxygen causing fire in the facility that resulted in burns to right shoulder, chest and back. Resident #2 failing to abide by facility policy with possession of electronic cigarette.

Corrective Actions:
1. On 2/21/21 at 3:06 pm Receptionist #1 called 911 while facility alarm was sounding. Alarm company also contacted fire department.

2. On 02/21/21 at 3:12 pm Fire department dispatched EnRoute to facility and arrived at 3:14 pm. Sprinkler system was actively spraying water causing excessive smoke. Sprinkler system extinguished the fire prior to arrival of Fire Department. On 02/21/21 at 3:15 pm LPN #2 called 911 requested ambulance.

3. On 02/21/21 at 3: 12 PM Resident #1 was assessed by RN (Registered Nurse) #1. Resident #1 had burns to right front and rear shoulder, Right Scapula, and Right side of chest. Ambulance Service arrived at facility at 4:06 PM and begin further evaluation of Resident and transferred to burn center. The facility has no outside legal representative for Resident #1. Resident #1 is his own responsible party. The facility initiated an investigation.

4. On 02/21/21 at 3:15 PM Remaining twenty-three (23) Residents in fire door area begin being escorted to outside parking lot to account for and ensure safety.

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5. On 2/21/21 at 4:40 PM Nurse Practitioner (NP)#1 assessed a total of twenty-three (23) Residents which previously resided in affected area. No concerns identified. On 02/24/21 Psychiatric Nurse Practitioner (NP) assessed a total of twenty-three (23) Residents for any emotional distress or trauma as related to the fire with no abnormalities noted. Staff Support hotline posted to provide grief or mental health support due to fire.

6. On 02/21/21 at 5:02 PM Mississippi State Department of Health was notified of event.

7. On 02/21/21 at 6:30 PM Fire Marshall assessed building for any safety issues regarding the fire and cleared the remaining unaffected area to allow occupancy.

8. On 02/21/21 at 6:30 PM Resident rooms involved in evacuation area were assessed for water damage by outside contractor and Residents were actively being relocated to other areas of the building by facility staff. Relocation of twenty-three (23) Residents were completed by 10:30 PM. From 6:30 PM to 10:30 PM Responsible Parties of Residents residing in facility were contacted regarding event and safety of Residents by administration staff.

9. On 02/21/21 beginning at approximately 8:00 PM Administrator, Director of Nurses (DON), and Staff Development Coordinator (SDC) initiated education with staff, including Certified Nursing Assistants, licensed nurses, housekeeping staff, business office staff, therapy staff, dietary staff and administrative staff on Abuse and Neglect Prohibition Policy, Resident Rights, Emergency

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Operations Plan, Fire Evacuation, Smoking Evaluations, and Resident Safety regarding fire. No staff will be allowed to return to work without completing.

10. On 02/22/21 at 5:00 PM, facility Administrator initiated automated phone reporting system alert to Resident families and staff to inform smoking safety including facility storage of lighters, asking families not to purchase flammable materials including new revisions to policy with removal of lighters regardless of smoking safety status. On 03/08/21 at 8:40 PM facility Administrator initiated automated phone reporting system with updated alert including revisions on smoking policy with facility storage of all smoking materials and assigned smoking times. This system automatically sends alerts and contacts families and staff listed in Resident's record and payroll system.

11. On 02/23/21 at 4:30 PM, the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing (Infection Preventionist) , Nurse Practitioner, and Clinical Corporate Consultant held Quality Assurance Performance Improvement meeting to include immediate corrective actions following facility fire involving audits on facilities current smoking Residents with room checks, smoking evaluations, smoking safety equipment, room change notifications, updated Brief Interview Mental Status (BIMS), and care plan reviews. Smoking policy was discussed with revision to remove wording that residents may retain their lighters if deemed safe. Resident's room checks were initiated on 2/21/21 with smoking residents to remove all lighters. Room checks were completed on 2/22/21 with multiple lighters found.

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12. On 03/08/21 at 6:45 PM, the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing and Clinical Corporate Consultant held Quality Assurance Performance Improvement meeting following notification of Immediate Jeopardy to review steps initiated to prevent any further reoccurrence including new policy and procedure changes. The smoking policy was revised to include supervised smoking of all Residents, assigned smoking times, and facility storage of all smoking material.

13. On 02/24/21 at 11:01 AM final written investigation was sent to Mississippi Department of Health along with Mississippi State Attorney General at 4:55 PM.

14. On 03/03/21 at 11:00 AM Mississippi State Department of Health Life Safety Surveyor entered facility to assess affected area with no negative findings.

15. On 03/08/21 at 3:45 pm E-cigarettes and smoking materials removed from Resident #2 possession, Assistant Director of Nurses (ADON) and Social Service Director (SSD) attempted education on new smoking policy and Resident #2 declined education. At 6:00 PM Smoking evaluation completed by Director of Nurses (DON) on Resident #2 revised to indicate Supervised smoking in designated smoking area during assigned smoking times. On 3/9/21 100% room checks of all one hundred and thirty-one (131) resident's room were initiated to remove all smoking materials. No lighters were found. Two electronic cigarettes were removed to include Resident #2. There are no Residents with possession of smoking materials completed on

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3/9/21 at 9:00 am.

16. On 03/08/21 at 6:00 PM Director of Nursing (DON) initiated new smoking evaluations on residents along with care plan updates on resident that smoke reflecting safety needs and policy changes. One hundred and Thirty-one (131) Resident smoking evaluations were completed with Twenty-one (21) Resident smoking care plans adjusted. On 3/9/21 at 7:30 am door to smoking area was secured, and scheduled smoking times begin starting at 9:00 am.

17. On 03/08/21 beginning at approximately 7:00 PM Staff Development Coordinator (SDC) initiated education with staff, including Certified Nursing Assistants, licensed nurses, housekeeping staff, business office staff, therapy staff, dietary staff, and administrative staff on new smoking policy revisions. No staff will be allowed to return to work without completing.

18. On 03/09//21 at 9:15 AM education begin on new smoking policy revision with current smoking residents and smoking materials removed from current smoking resident's possession to include lighters, and cigarettes, on 03/09/21 at 8:30 AM keypad locked entry located at designated smoking area on lower first floor activated to ensure supervised access followed.

19. On 03/09/21 at 10:15 AM Resident Council Meeting Held with Activities Director, Resident Council President, and fifteen (15) resident members present to discuss new smoking policy revisions with supervised smoking times, and changes in facility storage of smoking materials.

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	255146	A. BUILDING _____ B. WING _____	C 03/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

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20. Facility is alleging that all activities to remove the Immediate Jeopardy were completed as of 03/09/21, and the Immediate Jeopardy was removed 03/10/21.

The SA validated the Removal Plan on 03-11-2021, and determined the IJ was removed on 03-10-2021, prior to exit. Therefore, the scope and severity for 42 CFR §483.90(i)(5) - Smoking Policies (F926) - Scope and Severity - "L" was lowered from an "L" to an "F", while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory compliance.

1. On 2/21/21 at 3:06 PM Receptionist #1 called 911 while facility alarm was sounding. Alarm company also contacted fire department.
- Verified by the SA via review of the call log and interview.

2. On 02/21/21 at 3:12pm Fire department dispatched EnRoute to facility and arrived at 3:14 pm. Sprinkler system was actively spraying water causing excessive smoke. Sprinkler system extinguished the fire prior to arrival of Fire Department. On 02/21/21 at 3:15 PM LPN #2 called 911 requested ambulance.
- Verified by the SA via review of the Fire Departments call log journal and report.

3. On 02/21/21 at 3: 12 PM Resident #1 was assessed by RN (Registered Nurse) #1. Resident #1 had burns to right front and rear shoulder, Right Scapula, and Right side of chest. Ambulance Service arrived at facility at 4:06 PM and begin further evaluation of Resident and transferred to burn center. The facility has no

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outside legal representative for Resident #1. Resident #1 is his own responsible party. The facility initiated an investigation.
- Verified by the SA through review of Resident #1's medical record.

4. On 02/21/21 at 3:15 PM Remaining twenty-three (23) Residents in fire door area begin being escorted to outside parking lot to account for and ensure safety.
- Verified by the SA through interview of residents, and review of prior census sheet verses current census sheet of locations.

5. On 2/21/21 at 4:40 PM Nurse Practitioner (NP)#1 assessed a total of twenty-three (23) Residents which previously resided in affected area. No concerns identified. On 02/24/21 Psychiatric Nurse Practitioner (NP) assessed a total of twenty-three (23) Residents for any emotional distress or trauma as related to the fire with no abnormalities noted. Staff Support hotline posted to provide grief or mental health support due to fire.
- Verified by the SA through interview of residents, and review of visit notes in their medical records.

6. On 02/21/21 at 5:02 PM Mississippi State Department of Health was notified of event.
- Verified by the SA through review of the report.

7. On 02/21/21 at 6:30 PM Fire Marshall assessed building for any safety issues regarding the fire and cleared the remaining unaffected area to allow occupancy.
- Verified by the SA through review of the Fire Marshall's report, and occupy order.

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8. On 02/21/21 at 6:30 PM Resident rooms involved in evacuation area were assessed for water damage by outside contractor and Residents were actively being relocated to other areas of the building by facility staff. Relocation of twenty-three (23) Residents were completed by 10:30 PM. From 6:30 PM to 10:30 PM Responsible Parties of Residents residing in facility were contacted regarding event and safety of Residents by administration staff.
- Verified by the SA through resident interview, as most are their own responsible parties, medical record review and family call log review.

9. On 02/21/21 beginning at approximately 8:00 PM Administrator, Director of Nurses (DON), and Staff Development Coordinator (SDC) initiated education with staff, including Certified Nursing Assistants, licensed nurses, housekeeping staff, business office staff, therapy staff, dietary staff and administrative staff on Abuse and Neglect Prohibition Policy, Resident Rights, Emergency Operations Plan, Fire Evacuation, Smoking Evaluations, and Resident Safety regarding fire. No staff will be allowed to return to work without completing.
- Verified by the SA through sign-in sheet review and staff interviews.

10. On 02/22/21 at 5:00 PM, facility Administrator initiated automated phone reporting system alert to Resident families and staff to inform smoking safety including facility storage of lighters, asking families not to purchase flammable materials including new revisions to policy with removal of lighters regardless of smoking safety status. On 03/08/21 at 8:40 PM facility Administrator initiated automated phone reporting system with updated alert including revisions on smoking policy with

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facility storage of all smoking materials and assigned smoking times. This system automatically sends alerts and contacts families and staff listed in Resident's record and payroll system.
- Verified by the SA through review of the transcript provided by "Voice Friend Reporting" and the call times messages were sent out.

11. On 02/23/21 at 4:30 PM, the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing (Infection Preventionist) , Nurse Practitioner, and Clinical Corporate Consultant held Quality Assurance Performance Improvement meeting to include immediate corrective actions following facility fire involving audits on facilities current smoking Residents with room checks, smoking evaluations, smoking safety equipment, room change notifications, updated Brief Interview Mental Status (BIMS), and care plan reviews. Smoking policy was discussed with revision to remove wording that residents may retain their lighters if deemed safe. Resident's room checks were initiated on 2/21/21 with smoking residents to remove all lighters. Room checks were completed on 2/22/21 with multiple lighters found.
- Verified by the SA via review of the sign-in sheet, review of the content of the meeting items discussed, and staff interviews.

12. On 03/08/21 at 6:45 PM, the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing and Clinical Corporate Consultant held Quality Assurance Performance Improvement meeting following notification of Immediate Jeopardy to review steps initiated to prevent any further reoccurrence including new policy and procedure changes. The

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smoking policy was revised to include supervised smoking of all Residents, assigned smoking times, and facility storage of all smoking material.
- Verified by the SA via review of the sign-in sheet, review of the content of the meeting items discussed, and staff interviews.

13. On 02/24/21 at 11:01 AM final written investigation was sent to Mississippi Department of Health along with Mississippi State Attorney General at 4:55 PM.
- Verified by the SA through review of the report received and a copy of the fax sheet that was timed and dated.

14. On 03/03/21 at 11:00 AM Mississippi State Department of Health Life Safety Surveyor entered facility to assess affected area with no negative findings.
- Verified by the SA through review of the LSC Surveyors report

15. On 03/08/21 at 3:45pm E-cigarettes and smoking materials removed from Resident #2 possession, Assistant Director of Nurses (ADON) and Social Service Director (SSD) attempted education on new smoking policy and Resident #2 declined education. At 6:00 PM Smoking evaluation completed by Director of Nurses (DON) on Resident #2 revised to indicate Supervised smoking in designated smoking area during assigned smoking times. On 3/9/21 100% room checks of all one hundred and thirty-one (131) resident's room were initiated to remove all smoking materials. No lighters were found. Two electronic cigarettes were removed to include Resident #2. There are no Residents with possession of smoking materials completed on 3/9/21 at 9:00 am.

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- Verified by SA via resident interview, reviewing new assessments within the medical records against the checklist of current smokers.

16. On 03/08/21 at 6:00 PM Director of Nursing (DON) initiated new smoking evaluations on residents along with care plan updates on resident that smoke reflecting safety needs and policy changes. One hundred and Thirty-one (131) Resident smoking evaluations were completed with Twenty-one (21) Resident smoking care plans adjusted. On 3/9/21 at 7:30 am door to smoking area was secured, and scheduled smoking times begin starting at 9:00 am.
- Verified by the SA through review of the new smoking assessments dated for 03-08-2021 in the medical records of all residents currently in the building.

17. On 03/08/21 beginning at approximately 7:00 PM Staff Development Coordinator (SDC) initiated education with staff, including Certified Nursing Assistants, licensed nurses, housekeeping staff, business office staff, therapy staff, dietary staff, and administrative staff on new smoking policy revisions. No staff will be allowed to return to work without completing.
- Verified by the state agency through review of the sign-in sheet and staff interviews.

18. On 03/09//21 at 9:15 AM education begin on new smoking policy revision with current smoking residents and smoking materials removed from current smoking resident's possession to include lighters, and cigarettes, on 03/09/21 at 8:30 AM keypad locked entry located at designated smoking area on lower first floor activated to ensure supervised access followed.

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F 926	Continued From page 85 - Verified by the SA through interviews with the residents who smoke, and the new code pad installed next to the door with numeric code entry to unlock it. 19. On 03/09/21 at 10:15 AM Resident Council Meeting Held with Activities Director, Resident Council President, and fifteen (15) resident members present to discuss new smoking policy revisions with supervised smoking times, and changes in facility storage of smoking materials. - Verified by the SA through review of the council sign-in form, and resident interview regarding topics discussed and understanding. 20. Facility is alleging that all activities to remove the Immediate Jeopardy were completed as of 03/09/21, and the Immediate Jeopardy was removed 03/10/21. - The SA verified all aspects of the Removal Plan had been carried out as stated, and the Immediate Jeopardy was removed on 03-10-2021, as stated.	F 926		