STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255182	A. BUILDING _____ B. WING _____	C 02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW NURSING CENTER	16411 ROBINSON ROAD GULFPORT, MS 39503

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted two (2) Complaint Investigations (CI MS #24274 and CI MS #24301), at the facility from 2/26/24 through 2/28/24. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. CI MS #24274 was a facility reported incident related to resident safety and F656 and F689 was cited. CI MS #24301 was investigated for pressure sores, inappropriate feeding assistance, resident left soiled, and notification of resident representative and there were no deficiencies cited related to the investigation. The facility held a license for 105 beds and had a census of 85 at the time of the survey.	F 000		
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		3/15/24

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

Electronically Signed | 03/08/2024

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F 656	Continued From page 1 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and facility policy reviews, the facility failed to implement care plan approaches related to prohibiting the use of oxygen in the smoking area for one (1) of four (4) sampled resident's care plans. Resident #1. Findings Include: Record review of the facility's "Comprehensive Care Plans" policy date implemented 4/3/20, revealed, "...It is the policy of this facility to	F 656	*On 2/21/2024, The facility staff failed to implement care plan approaches on resident #1 related to prohibiting the use of oxygen in the smoking area. Minimum Data Set (MDS) Coordinator revealed that care plans are individualized for each resident and provide direction for the staff on providing care. MDS coordinator inserviced Activity Director (AD) 2/21/24 on the importance of reviewing and following resident care plans to prevent	

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F 656	Continued From page 2 develop and implement a comprehensive person-centered care plan for each resident ..." A record review of the "Care Plan" with a problem onset date of 11/6/23 revealed "Problem/Need: SMOKING I am a smoker and requires supervision...Approaches...Supervise all smoking...Prohibition of oxygen use in the smoking area..." A record review of the facility investigation revealed on 2/21/24, the Activities Director (AD) was assisting with the smoke break at the facility with her back turned and heard a "popping/clicking" sound. Upon turning, she observed sparks coming from Resident #1's nasal cannula. She immediately removed the cannula and turned his oxygen off. Record review of the "Physician Orders" for February 2024 revealed Resident #1 had a physician order dated 11/9/23 for "...Oxygen at 2 LPM (liters per minute) VIA (by way of) nasal cannula ..." During an interview on 2/26/24 at 3:45 PM, with Resident #1, he confirmed on 2/21/24 that while in his wheelchair with his oxygen on, he went to the smoking area without having his oxygen removed before entering the smoking area. In an interview on 2/27/24 at 10:21 AM, with the AD confirmed on 2/21/24 she failed to remove Resident #1's oxygen canister from his wheelchair before he entered the smoking area. On 2/27/24 at 11:00 AM, during an interview with Registered Nurse (RN) #1/Minimum Data Set (MDS) nurse, confirmed Resident #1's care plan	F 656	potentially serious outcomes. **All residents are at risk for this deficient practice. ***MDS coordinator and MDS assessment nurse began an inservice with all current staff on 2/22/24 on the importance of reviewing and following resident care plans to prevent potentially serious outcomes. The inservices will be completed on 3/15/24. ****Quality Assurance (QA) nurses will monitor all residents at risk for smoking beginning on 2/22/2024. Five care plans for residents at risk for smoking will be monitored beginning on 2/22/2024 weekly x four weeks and monthly x three months and will be brought to standup for interdisciplinary team review. Findings will be brought to QA meeting beginning on 3/12/2024 x three months.	

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F 656	Continued From page 3 was not implemented because his oxygen tank and nasal cannula were still on the resident's wheelchair before he entered the smoking area. She revealed that care plans are individualized for each resident and provide direction for the staff on providing care. She confirmed that she expects staff to follow the care plans. During an interview with the Director of Nurses (DON), on 2/27/24 at 12:00 PM, confirmed Resident #1 was brought to the smoking area with his oxygen and nasal cannula still present. The DON stated the staff did not follow the care plans for removing the resident's oxygen canister before he entered the smoking area. The care plans are in place for staff to care for the residents. It is expected that the facility staff will follow the residents' care plans. A record review of the "Face Sheet" revealed the facility admitted Resident #1 on 11/6/23 with diagnoses that included Chronic obstructive pulmonary disease and Heart failure.	F 656		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to	F 689	*Brief summary of events: The facility failed to provide a safe smoking	3/15/24

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F 689	Continued From page 4 provide a safe smoking environment when the facility staff did not remove an oxygen (O2) canister from Resident #1 prior to entering the smoking area and did not secure a cigarette lighter to prevent Resident #1 from lighting a cigarette. This failure resulted in Resident #1 receiving burns to his face. This was for one (1) of three (3) sampled residents reviewed for smoking. Findings Include: Review of the facility's policy, "Accidents and Supervision", dated 12/9/2020, revealed, "Policy: The resident environment will remain as free of accident hazards as is possible ...This includes ...3. Implementing interventions to reduce hazard(s) and risk(s) ... Policy Explanation and Compliance Guidelines ...3. Implementation of Interventions ...i. Resident-directed approaches may include ...supervising ...residents ..." Review of the facility's policy, "Resident Smoking, Smokeless Tobacco, and Vaping Policy," dated 3/29/22, revealed, " Policy: This facility provides a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking ...Policy Explanation and Compliance Guidelines ...2. Safety measures for the designated smoking area will include ...e. Prohibition of oxygen use in the smoking area ...11. All safe smoking measures will be documented on each resident's care plan and communicated to all staff ...who will be responsible for supervising residents while smoking ...14. All smoking materials of residents will be maintained by nursing and/or activity staff ..."	F 689	environment when the facility staff did not remove an oxygen (O2) canister and nasal cannula from resident #1 prior to entering the smoking area and did not secure a cigarette lighter to prevent resident #1 from lighting a cigarette. This failure resulted in resident #1 receiving burns to his face. On 2/21/24 License Practical Nurse (LPN) #1 promptly treated resident #1 and sent resident #1 to the hospital for evaluation and treatment. **All residents who smoke have the potential to be affected by this deficient practice. ***Two staff members will be present at all designated smoke breaks. The cigarettes and lighter will remain in possession of a staff member at all times and all cigarettes will be lit by staff member only. Oxygen canisters will not be permitted in designated smoking area and will be removed by a staff nurse prior to entering smoking area. Director of Nursing (DON) began an inservice with all current staff on 2/21/24 on the revised smoking policy, abuse/neglect/exploitation policy and accidents and supervision policy. The inservices will be completed on 3/15/24. ****Beginning on 2/26/2024 Quality Assurance (QA) nurses will monitor all residents during three of three smoke breaks daily x five days. Then one smoke break biweekly x four weeks and monthly	

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F 689	Continued From page 5 A record review of the facility's investigation, dated 2/23/24, revealed on 2/21/24, when the Activities Director (AD) was assisting with the smoke breaks with her back turned, she heard a "popping/clicking" sound. Upon turning, she observed sparks coming from Resident #1's oxygen nasal cannula. She immediately removed the cannula and turned his oxygen off. Record review of the local hospital report, dated 2/21/24, revealed "... Arrival Complaint FACIAL BURN Chief Complaint... Complaint of facial burns to bilateral nostrils after lighting a cigarette while wearing home O2...singed hair at nares ...Final diagnoses Second degree burn of nose. Partial thickness burns of face ..." Discharge Orders revealed Resident #1 received Keflex (antibiotic medication) and a Bacitracin Ointment (treatment order) upon discharge. Record review of the "Physician Orders" for the month of February 2024 revealed Resident #1 had an order, dated 11/9/23, for "Oxygen at 2 LPM (Liters per minute) via nasal cannula as needed ..." A record review of the "Resident Safe Smoking Assessment", dated 11/13/23, revealed Resident #1 was able to verbalize the safety risks of smoking and was aware of smoking procedures. On 2/26/24 at 3:45 PM, during an interview with Resident #1, he confirmed on 2/21/24, he went into the smoking area with an O2 canister on the back of his wheelchair and the O2 was being delivered through a nasal cannula. Resident #1 expressed that it was his fault because he was rushing to make it to the smoke area and forgot to have his oxygen canister removed from his	F 689	x three months. Findings will be brought to QA meeting beginning on 3/12/2024 x three months.	

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F 689	Continued From page 6	F 689		

wheelchair. He said he was anxious about being late, so he got the lighter from the box that holds the smoking items and he lit his cigarette instead of waiting for staff to light it for him. He stated that the lighter sparked and he pulled the nasal cannula off. He said that it did not hurt him and he did not want to go to the hospital, but the facility insisted he get checked out.

On 2/26/24 at 4:00 PM, during an observation of the residents during the smoking break, the cigarettes and lighters were observed in a plastic container with the top not secured on a table in the smoking area. There were two (2) facility staff supervising and assisting the residents and were using the container to pass out cigarettes for the residents and then using a lighter to light the cigarettes.

On 2/27/24 at 10:21 AM, during an interview with the AD, she confirmed that on 2/21/24 at approximately 4:00 PM, she assisted Resident #1 during the smoke break. She confirmed that she did not remove his oxygen canister as she usually did before he entered the smoke area. The AD explained Resident #1 was late getting to the smoking area and while she was assisting another resident through the doorway, he got a lighter out of the box that was left on a table. She heard a "clicking/popping sound" and observed sparks coming from the nasal cannula. She assisted with removing the nasal cannula, turned the oxygen off, and got a nurse to assist.

On 2/27/24 at 10:50 AM, during an interview with License Practical Nurse (LPN) #1, she confirmed on 2/21/24, the AD called out for assistance in the smoking area. LPN #1 stated she observed Resident #1 having soot (ashes) on his nasal

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F 689	Continued From page 7	F 689		

passages, bridge of his nose, and inside his nares, face, and right shoulder. She explained that the sparks had been put out before she went to the smoking area. She stated that she immediately notified the Director of Nursing (DON) and the Administrator.

On 2/27/24 at 12:00 PM, during an interview with the DON, confirmed that Resident #1 was brought to the smoking area while wearing O2 and had an O2 canister on the back of his wheelchair. The DON stated the AD failed to remove both the resident's oxygen and nasal cannula during his smoke break, which caused sparks. Resident #1 went to the hospital and was treated for a second degree burn of the nose and partial thickness burn of the face.

During an interview with the Administrator on 2/27/24 at 2:33 PM, she confirmed that on 2/21/24, Resident #1 lit his cigarette before the AD checked or removed his O2. The Administrator stated safety is the utmost priority of the facility, and moving forward, the facility has placed more checks and balances to prevent further incidents or accidents.

A record review of the "Face Sheet" revealed the facility admitted Resident #1 on 11/6/23 with current diagnoses including Chronic Obstructive Pulmonary Disease and Heart Failure.

Record review of the Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/15/23 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated he was cognitively intact. Section J revealed Resident #1 currently uses tobacco. Section O revealed Resident #1 used

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F 689	Continued From page 8 oxygen therapy.	F 689		