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	255106	A. BUILDING _____ B. WING _____	C 01/28/2022

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BRANDON NURSING AND REHABILITATION CENTER	**355 CROSSGATE BLVD BRANDON, MS 39042**

(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 a Complaint Survey at the facility from 1/26/2022 through 1/28/2022 for Complaint Investigations (CI) MS #18458 for alleged staff to resident physical abuse, CI MS #18455 for a fire in the facility caused when a resident used a cigarette lighter while wearing oxygen causing a fire with injuries of burns to the resident, CI MS #18372 for alleged neglect of a resident not being changed timely, and CI MS #18364 for alleged pressure ulcers developed in the facility. During the survey, the SA determined the facility was not in compliance with the requirements of participation for Medicare and Medicaid. The SA did not substantiate MS #18458, MS #18372, and MS #18364. The SA did substantiate MS #18455 and cited F689. During the survey, the SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 1/20/2022, when the facility failed to ensure a resident was supervised and the resident's environment was free from hazards when the resident set fire to bed linens, bed mattress, oxygen concentrator, and privacy curtain with a cigarette lighter. This incident resulted in serious injury and serious harm for Resident #1 and placed all resident's and staff in a situation that caused or was likely to cause serious injury, harm, impairment, or death. The IJ and SQC existed at 42 CFR(s): 483.25 (d)(1)(2)-Free of Accidents, Hazards/ Supervision/device (F689). On 1/27/2022 at 10:30 AM, the SA notified the Administrator of the IJ and SQC and provided the facility with the IJ template.	F 000	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/16/2022

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F 000	Continued From page 1 Based on the facility's implementation of corrective actions on 1/21/2022 and SA review, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed as of 1/22/2022, prior to the SA's entrance on 1/26/2022. The census at the time of survey was 213 and the facility held a license for 230 beds.	F 000		
F 689 SS=J	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, interview, record review and facility policy and procedure review the facility failed to provide Resident #1 (Res #1) with the supervision that he required to prevent accidents, hazards of a facility fire, which caused Res #1 severe burns and hospitalization, with numerous surgeries of skin grafts. Resident #1 received more than minimal harm from the facility's lack of supervision. Res #1 was severely burned over his upper body when he used a cigarette lighter while in his bed wearing oxygen. Res #1 set himself on fire along with his bed linens, mattress, oxygen tubing, mask, oxygen concentrator, and the privacy curtain. There were 213 residents living in the facility at the time of the fire. Resident #1	F 689	Past noncompliance: no plan of correction required.	2/15/22

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was one (1) of 213 Residents to suffer serious harm from the fire on 1/20/2022.

On 01/27/2022 at 10:30 A.M. the facility notified of an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) was provided the IJ Template for F689=J, Past Non-Compliance, for failure to prevent Accidents Hazards and lack of Supervision, which caused more than minimal harm to Res #1 when he started a fire in his bed while wearing oxygen. Res #1 had burns over his body and was placed in the hospital, where he remains to date.

Based on the facility's implementation of a Corrective Action Plan as of 01/20/2022 and 01/21/2022, prior to the State Agency (SA) entering the facility on 01/26/2022, the SA determined that the IJ and the Substandard Quality of Care (SQC) was Past Non-Compliance (PNC) and the IJ was removed as of 01/22/2022.

Findings include:

Review of the facility policy and procedure entitled "Smoking", dated 11/17 revealed, " ...Procedure: 1..Residents that are evaluated as independent with smoking: (and/or without history of smoking incidents; needing no interventions) will be permitted to keep and maintain their own smoking materials (i.e. cigarettes, e-cigarettes), and may smoke in designated areas without limitations ..."

Review of the Smoking Policy Amendment revealed, "Effective 01/21/2022, Residents will not be allowed to possess lighters or matches. Wall mounted cigarette lighters are present in the designated smoking area (courtyard)

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Independent Residents will continue to be allowed to keep their cigarettes. Nursing staff will monitor all Residents' rooms every shift to ensure no lighters are present."

Review of the facility policy and procedure dated 7/18 entitled: Accident and Incidents Hazard Reports revealed: Employees shall be aware of potential hazards and all accidents or unsafe practices shall be reported. Employees shall understand how to accomplish their job(s) safely. New employees are to be assisted in developing safe practices.

Interview on 1/26/22 at 8:50 AM, with the Facility Administrator (ADM) revealed that Res. #1 set his bed and his bed linen on fire as a result of playing with a cigarette lighter. 911 was called to the facility and upon the arrival of the Fire Department the staff of the facility had the fire put out and had begun assessing all residents on the unit and had begun assessing Res #1. The ADM stated that she was contacted immediately of the fire by the facility staff. The ADM arrived at the facility at approximately 10:00 P.M. The ADM stated that the EMT's (Emergency Medical Technologists) took over the assessment of Res #1 and transported Resident #1 to the local ER (Emergency Room) located across the street from the facility. The ER transferred Res. #1 to a "burn unit" for specialized care to the burns to his upper body. She stated that she "self-reported" the facility fire and the burns to Res #1 to the State Agency (SA) and to the Attorney General (AG) office on 1/20/22 at 10:15 P.M. The ADM stated that the Responsible Party (RP) of Res #1 was also contacted and given a report as to what had happened. The ADM stated that when she talked to the RP, he apologized to her and told

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her that Res #1 had been involved in another episode of fire from a cigarette lighter and oxygen several years ago. The RP said to ADM "I am so sorry he did this." The ADM stated that the burned bed and linens have been disposed of and are no longer at the facility for viewing. She stated that the room that contained the fire has been cleaned and has been closed off and no other residents were placed in that room since the fire of 1/20/22.

Interview and observation on 1/26/22 at 9:30 AM, with the Regional Vice President (VP) revealed that she had been notified of the fire in the facility, caused by Res #1 "playing" with a cigarette lighter. The VP stated that she arrived at the facility at approximately 10:00 P.M. and began investigating the fire and in-servicing the staff and residents. She stated that the Quality Assurance Team (QA) met on 1/21/22 and immediately changed the facility smoking policy and re-educated all staff and all residents on the "new policy" changes. The QA team changed the policy to read that "no" resident may have possession of lighters and/or matches. The VP stated that all resident smokers were re-assessed on 1/21/22 and care plans updated. The VP stated that the QA team went room to room and did complete room checks and confiscated any and all lighters and matches that were found. The QA team and all working staff will conduct daily surveillance of all areas and resident rooms each morning. When lighters and matches are found they will be taken and given to the Social Worker and/or the unit supervisor to keep for the resident. The VP stated that since the fire in the facility on 1/20/22, letters were sent out to all RP's concerning the changes in the smoking policy and that "no resident" no matter what their cognitive status,

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will be allowed to possess lighters and/or matches. The VP had pictures on her cell phone, that she showed to surveyor, of the bed that Res #1 set on fire. The bed and bed linen were very badly burned. In the pictures, that the VP shared, it appeared that the top portion of the bed had a circle of black ashes approximately 16-20 inches in diameter and possibly 1-2 inches deep. The mattress stuffing and the bed linens were black with fire markings and ashes. The VP stated that Res #1 had suffered burns to the upper portion of his body, on his chest, left arm, face, and back. The VP stated that Res #1 remained calm and talking to staff during the assessing process after the fire on the night of 1/20/22. She stated that all staff and all residents had been re-inserviced and re-educated on the changes to the Smoking Policy and all corrective actions had been completed prior to the surveyors entering the facility on 1/26/22.

Record review of the facility's Nursing Notes dated 1/21/2022 revealed, "At 2139, I (name of LPN#4) received a call from (name of LPN) that resident (Res #1) was on fire. I had been on break for 10 minutes when I received the phone call. I rushed back to the facility and made it back within 5 minutes. At that time, resident (Res #1) was up in W/C (wheelchair) and sitting at the door towards the back of the facility with the fire department at resident's side. (Name of LPN) was also at resident's side monitoring his 02 (oxygen) SATS (Saturation) and his oxygen. Resident was receiving 2L (2 liters) via face mask and his SATS were stable at 93%. Resident's back had been severely burned, upper back looked yellow in color. His left arm was black all around his elbow, above and below it. When resident was asked what happened he said he

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flicked a lighter and then flames sparked and then he was on fire. Resident wears 02 at 2L (2 liters) via nasal cannula at all times when in his room. Resident's RP, (name of brother) was notified around 2200. (Name of RP) response was "I'm so sorry that he did that. I'm glad that all of y'all are okay. He's had this happen before when he lived at home. Thank you so much for calling me." Resident was sent out at 2235 via (name of ambulance company) to the hospital."

Interview and observation on 1/26/22 at 10:10 AM, with the Director of Maintenance (DM) revealed that the fire was caused by Res #1 "playing" with a cigarette lighter as he laid in bed on 1/20/22 at approximately 9:00-9:30 PM. The DM confirmed that the smoke detectors picked up the scent of smoke and automatically sounded the fire alarms and summoned the local Fire Department. The DM stated that the sprinkler system did not deploy because they are heat activated and the heat did not become severe enough to set off the water sprinklers. There was a good amount of smoke from the burning bed and linens and the smoke alarms were deployed/activated. The local Fire Department arrived on the unit within five (5) to ten (10) minutes after the smoke alarms were activated. When the Fire Department arrived the staff on the unit had extinguished the fire safely and had begun administering care to Residents. The DM stated that he arrived on the unit approximately five (5) minutes after the local Fire Department had arrived and the Fire Department had placed fans in the hallways to draw out the smoke that had accumulated in the halls and inside of Res #1's room. DM stated that he stayed at the facility that night until after midnight securing Res #1's room and clearing the air as well as assisting

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the staff with safety measures.

The observation on 1/26/22 at 10:10 AM, of Res #1's room was made with the DM and with the State Fire and Safety surveyor. The DM had to use an electric screwdriver to unbolt the door to Resident #1's room in order to let the surveyors inside the room for observation. The room door had been bolted/screwed shut in order to keep people from entering the room where the fire had taken place. Upon entering the room was empty. There was no furniture, no window dressings, no privacy curtains, and no beds in the room. The room contained a white powered residue scattered about on the floor, and on an oxygen concentrator that was in the room. The oxygen concentrator had some small black soot marks located on the outside of the concentrator. The DM stated that he had disposed of the burned bed and linens of Res #1. He stated that the bed and the bed linen of Res #1 had been burned with what looked like approximately an area of 14-16 inches in diameter. The DM stated that he had no pictures of the burned bed and bed linens. He stated that when he arrived at the facility on 1/20/22 at approximately 9:30 P.M. the Fire Department and staff had removed the resident from the room and were administering treatment to Res #1. He stated that most of the smoke had been removed when he arrived by the fans that were placed in the hallways by the Fire Department. The DM pointed to the ceiling above where Res #1's bed was positioned to a sprinkler. The DM stated that the heat from the burning bed did not reach the water sprinkler and thus it was not activated. He stated that he in-serviced the facility staff monthly on Fire Prevention and taught all employees how to locate and use fire extinguishers. The DM confirmed that since the

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fire on 1/20/22 he had conducted Fire Prevention in-services and in-services on how to locate and use Fire Extinguishers. DM stated that all the staff and residents at the facility have been re-inserviced and educated again since the fire of 1/20/22.

Interview on 1/26/22 at 11:30 AM, via telephone with the Clinical Director, (MD) revealed he was contacted by the facility unit nurse that Res #1 had been burned from a fire that had been set in his room. The MD went to the facility and arrived at approximately 9:45 -10:00 P.M. and he stayed at the facility until approximately 2:00 A.M. The MD stated that when he arrived the EMT's were loading Res. #1 into the ambulance for transport to the ER. The MD said he talked to Res #1 and he had burns on his left arm, chest and back. Res #1's breathing was normal, but he was not able to physically assess the burns because Res #1 was on his way in the ambulance. The MD went to the unit and saw the smoke in the hallway of the 400 hall. MD stated that he talked to the physician (MD) that was assigned to the roommate of Res #1 and they felt that Res. #7, should be sent to the ER for a more thorough assessment, and to be on the safe side, since Res #7 was in the room asleep in his bed when the fire occurred. The MD stated that the ER assessed Res #7 and released him back to the facility with no injuries or damages. The MD stated that Res #1 was burned over his upper trunk and was transferred to the burn unit for further treatment. He assisted the facility to survey the unit and to assist with the residents after the local Fire Department left the facility. He met with the facility QA team, and they changed their facility resident Smoking Policy to not allow any resident to possess lighters and/or matches.

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The MD stated that to his knowledge Res #1 did not reveal where or how he obtained the lighter.

Interview on 1/26/22 at 1:00 PM, with Res.#7, roommate of Res #1 on the night of the fire, revealed that on the night of the fire he did not know where Res #1 got the cigarette lighter. "He wasn't supposed to have no lighter" Res #7 stated. Res #7 stated that he was in his bed in his room, and he saw Res #1 with a cigarette lighter in his hand and he "was playing with it" "he wasn't smoking." Res #1 lit his privacy curtain on fire first and then the fire got big and caught Res #1's bed on fire and set his clothes on fire. Res #7 stated that he turned on the call light and started calling out for help. Res #7 stated that he was not injured and was not scared. Res #7 stated that he felt safe at the facility. Res #7 stated that the staff came fast and put the fire out and then soon the fire department got there. Res #7 stated that he went to the ER for an assessment but was released back to the facility quickly. Res #7 stated that the residents were all told that none of them were allowed to have a lighter or any matches.

Interview on 1/26/22 at 1:22 P.M., with CNA#2 revealed that she was working the unit four the night of the fire on 1/20/22 and had been assigned to work with Res #1. CNA#2 stated that she never saw Res #1 with a lighter or matches. Res #1 had his call light on and then yelled help and the two CNA's, NA #1 and CNA#2 saw Res#1 on fire. CNA#2 stated that she and NA#1 went into Res #1's room and grabbed pitchers of water and ice and poured on Res #1. CNA#2 stated that Res #1 had on a short sleeve shirt and a pair of sweat pants, and his shirt was in flames and his chest and left arm was on fire. NA#1

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immediately poured a bedside pitcher of water on Res #1. The water put out Res #1's body flames, but the privacy curtain and his oxygen tubing and bed were still on fire. LPN#1 came with the fire extinguisher and sprayed it on the fire and oxygen tubing and concentrator. CNA#2 stated that Res #7 was in the bed next to Res #1, and he never moved or said a word. CNA#2 stated that she and NA#1 rolled Res #1 out of his room in his bed and got him to the nursing station for assessments. CNA#2 stated that Res #1 was burned on his left arm, face, chest, and back. CNA#2 stated that when they asked Res #1 what happened and how did the fire start, he opened his hand and had a cigarette lighter in his hand. Res #1 told the staff that he was not smoking in his room, but he was playing with the lighter.

Interview by telephone on 1/26/22 at 2:11 PM, with Res #1, and his brother, Responsible Party (RP) revealed that he was at the hospital with Res #1. He put the phone on speaker and the surveyor interviewed both RP and Res #1. Res #1 stated that he was not doing too good and that he had surgery for skin grafts. When surveyor asked Res #1 how the fire started and how did he get the lighter, he stated that he did not want to talk about it. RP stated that he felt like another resident had given the lighter to Res #1. RP stated that Res #1 was totally dependent upon others for all his needs. RP stated that he would have thought that Res #1 would have not used a lighter while wearing oxygen because several years prior he had experienced a younger brother to have gotten burned while wearing oxygen and smoking. RP stated that the doctors at the burn unit where Res #1 is confined, told them that Res #1 may need to have several more surgeries. RP stated that the facility contacted him the night of

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the fire and gave him a report of the fire and the hospital where Res #1 was taken.

Interview on 1/26/22 at 3:20 PM, with CNA#3 revealed that she was walking up the hall from unit three when she saw black smoke coming from Res #1's room and the black smoke quickly filled the hallways and the visibility down the hall was poor because there was so much smoke in the hallway in front of Res #1's room. She stated that the Unit Supervisor, LPN#6 announced over the intercom that there was a fire and for staff to report to help. She stated that it was hard to see in the hallways because there was thick smoke everywhere. The fire department got there quick and when they got to the facility the fire was out and smoke was everywhere. The fire department placed three (3) fans in the halls to blow the smoke out. CNA#3 stated that even though the staff had been trained numerous times of how to use the fire extinguishers and how to react in an emergency, it was much different when the "real thing" happened. We were all in shock and it was kind of a panic when the smoke got so thick, and the fire was burning the resident in his bed. "We all just kicked into survival mode and started running around shutting resident's doors and checking on everyone. It all happened so fast, and the fire department got there in a few minutes, and they took over telling everybody what to do and they got Res #1 and began assessing him and treating him and LPN#1. LPN#1 came with the fire extinguisher and put the fire out in the resident's room, and he inhaled smoke and the white stuff from the fire extinguisher. LPN#1 had to go to the ER and be treated too along with Res #1.

Interview on 1/26/22 at 3:45 PM, with NA #1

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revealed that she was assisting another resident the night of the fire when she was asked by the LPN to go to Res #1's room where the call light was on. NA #1 stated that she was on her way when she heard Res #1 yell out "Help." She stated that the tone of his voice was different than usual, and she knew something was bad wrong. When she got to the door of the room smoke was coming out into the hallway fast. She stated that she just reacted without thinking and poured water on Res #1 who was on fire in his bed. NA #1 stated that CNA #2 and CNA #3 brought more pitchers of water and she poured them on Res #1 to put him out. But the flames were so much, and the smoke was so dark and thick that the LPN#1 was hardly able to see to aim the fire extinguisher, but he sprayed the room everywhere and got the bed linens and mattress and the oxygen tubing and concentrator fire put out. The NA stated that she had put resident's body fire out prior to LPN#1 entering the room. NA #1 stated that the staff were all in shock and things happened so fast. NA #1 stated that the night of the fire they closed all the residents' doors to keep out the smoke and the fire department put out fans to draw out the smoke.

Interview on 1/26/22 at 4:30 PM, with CNA #4, stated that she assisted NA #1 and CNA #2 with getting Res #1 and Res #7 out of the room after the fire was put out. CNA#4 stated that they took both residents to the nursing station for assessments and then the fire department arrived, and they took over. CNA #4 stated that Res #1 was badly burning on his back and chest and left arm. CNA #4 stated that Res #1's arm was burned black and was sizzling and that his back was yellow and burned. CNA #4 stated that the mattress on Res #1's bed had a large hole

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burned in it and the privacy curtain was burned. CNA #4 stated that Res #1 told the staff that he had not been smoking in his room he opened his hand and handed over a lighter. Res #1 said "I was not smoking I was playing with the lighter."

Interview on 1/26/22 at 5:05 PM, with LPN#4, who was the Charge Nurse for hall 400 on 1/20/22. LPN#4 stated that she had given Res #1 his requested Morphine earlier in the shift and after giving all her medications to the resident on the 400 hall she left the unit at approximately 9:30 PM to go get some supper. While out of the facility the other nurse called her on her personal cell phone and told her that one of the residents that she had been assigned to on hall 400 had set himself on fire with a lighter and the fire department was there. LPN#4 stated that she quickly returned to the unit and upon arriving she saw the fans in the hall and the fire department and EMT's.

Interview on 1/26/22 at 5:30 PM, with LPN#1 revealed that he was the LPN on unit 300 on 1/20/22 when he saw dark thick smoke in the hallway of the 400 hall. The nurse announced over the intercom that there was a fire and please to report to unit 400. LPN#1 grabbed the fire extinguisher from the 300 hall and went running toward the 400 hall. He stated that it was hard to see because the smoke was so dark and thick. He went up the hall where the staff was guiding him to Res. #1's room and he went into the room that looked like it had flames coming up from the bed. He stated that he sprayed the fire extinguisher all over. He stated that the oxygen concentrator and the tubing were flaming with fire, so he sprayed them to put out the flames. LPN#1 stated that he had on his "N95" mask and

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that was probably why he did not get more smoke in his lungs. LPN#1 stated that he inhaled smoke and his mask was covered with black residue. The staff assisted him as did the fire department and they placed him on oxygen because his oxygen level was low. LPN#1 was transported to the ER for evaluation and was kept overnight for observation. LPN#1 stated that Res #1 was burned on his chest and arm and that his back was burned a yellow color. LPN#1 stated that the fire produced heavy dark smoke and it was hard to see in the hall and in the room. LPN #1 stated that the staff all acted quickly, and NA #1 had put Res #1 out with water pitchers prior to his arrival with the fire extinguisher.

Interview on 1/27/22 at 8:55 AM, with LPN #2 revealed that she serves as the Infection Control and Prevention Nurse and Staff Development Nurse. LPN#2 stated that she serves on the QA Committee/Team and that she began re-inservicing and re-educating all staff immediately after the fire of 1/20/22. LPN#2 confirmed that a QA Committee meeting was held first thing on 1/21/22 and the Smoking Policy was discussed and revised to read that no resident may possess a lighter and/or matches.

Interview on 1/27/22 at 10:15 AM, with Director of Maintenance (DM) revealed that he had conducted in-services on Accidents Hazards; Fire Prevention; and Fire Extinguishers Usage. The DM confirmed that all staff were required to attend the in-services. The DM stated that he began the re-education of staff on 1/20/2022. The DM stated that the staff were taught to use "Code Red" to announce a fire in the facility. DM stated that all staff had been re-trained and re-educated.

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Interview on 1/27/2022 at 12:50 PM with Resident (Res) #6, Resident Council President, revealed that she had been made aware of the fire caused by a cigarette lighter and the burns that a resident had received as a result of playing with a lighter while wearing oxygen. Res #6 stated that they hold resident council meetings on a monthly basis and they do discuss the Smoking Policy.

Interview on 1:10 P.M. with the Licensed Master Social Worker (LMSW), stated that the facility had a meeting on 1/21/2022 with all of the smokers in the building (33 smokers names were documented on the smokers list) and informed all that they were never to be in possession of a cigarette lighter and or matches. The LMSW also stated that all the smokers had been reassessed for smoking ability. The LMSW stated that all the smokers care plans had been revised on 1/20/22 and 1/21/22.

Record review of the "Resident Incident Report" dated 1/20/22 at 9:35 PM revealed "...Narrative of incident and description of injuries: Nurse heard CNA calling out that resident was on fire. Nurse went to room with fire extinguisher and put out fire on bed where resident was lying. Nurses assisted resident from bed to wheelchair. EMT's and fire department personnel at resident's side. Burns were noted to resident's upper and mid back, and back of left arm, above, on, and below his elbow. When asking resident what happened, resident stated "I flicked the liter and then it sparked and I was on fire." Burns on upper and mid back, left arm and around his elbow, above and below, hair on resident's left side of head had been singed in some areas..."

Record review of Res #1's Face Sheet revealed

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that Res #1 had an admission to the facility date of 6/26 2017, with diagnoses that were not limited to Chronic Obstructive Pulmonary Disease (COPD); Bipolar disorder; Epilepsy; Nicotine Dependence, other tobacco product, with other disorders; among other various diagnoses.

Record review on the Minimum Data Set (MDS) for Res #1 dated 1/24/22 revealed that Res #1 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated that Res #1 had moderate cognitive impairment.

Record review of the Care Plan dated 6/26/20217 read: Res #1 Is a Smoker and is at risk for complications associated with smoking i.e., SOB or possible Burns. Inform res#1 of New Smoking Policy, lighter free facility. Remind Res #1 that smoking is only allowed in designed areas outside of facility Res #1 is independent with smoking. Monitor Res #1 for possession of lighters and/or matches. This care plan was updated to include the actual complication on 1/20/2022 and will re-evaluated upon re-admission.

Record review of Res #1's Emergency Room (ER) progress note dated 01/21/22 revealed: Summary: (Res #1) was admitted to the ER with COPD; Hypertension; Bipolar Disorder; and Schizophrenia, Left leg amputation, complete left middle finger amputation; and who was admitted secondary for burns sustained while igniting nasal cannula oxygen. The patient states that he was in bed while using a lighter and his clothing and linens caught fire. Approximately 13% total body surface area burns were sustained to face left arm and left chest area. He was seen in the ER where he was admitted for further evaluation and

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workup of medical condition prior to going to surgery.

The record review of the Progress Note Report (local hospital) dated 01/26/22 for Res #1 revealed the patient is non-ambulatory with amputation of the lower extremity. He had full-thickness burns to the left upper extremity and to the anterior and posterior trunk. Patient was admitted to the ICU, seen by intensivist for medical management of multiple co-morbidities. He was taken to surgery on 01/23/2022 for excision and debridement with application of skin substitute to the trunk and left upper extremity for a total of 14 percent total body surface area burn injury. Hospitalist consulted for medical management continue silver nitrate soaks every 8 hours. Patient is scheduled to go to the OR (operating room) on January 31, 2022, for excision of wound, removal of skin substitute, application to skin substitute, in preparation for ReCell application surgery and all other indicated procedures. The patient is also scheduled to go to the OR on February 2, 2022, for surgical prep application of split thickness skin graft and application of ReCell and all other indicated procedures.

Record review of the daily Quality Improvement Rounds were reviewed for all residents. Documentation was reviewed and the QI Daily Rounds sheets contained checking rooms for lighters and matches.

The facility implemented the following Immediate Jeopardy (IJ) Corrective Action Plan, prior to the State Agency (SA) entering the facility on 01/26/2022.

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In response to the IJ and SQC cited on 01/27/2022 at 10:30 A.M., the facility submitted the following IJ Removal Plan that was accepted by the SA as Past Non-Compliance (PNC) on 01/27/2022 at 5:30 P.M.

Removal Plan-IJ--Residents supervision for environment to be free from hazards - Corrective actions:

1. Resident #1 was removed from the room by 3 PM - 11 PM Registered Nurse Supervisor with his vital signs and oxygen saturation taken. 911 was called. Resident #1 was evaluated by the Emergency Medical Technicians upon arrival to the facility and transferred to hospital with admission on 1/20/22. Resident #7 was sent to the emergency room on 1/20/22 for evaluation and returned to the facility with no injury. One staff member was sent to the emergency room for evaluation on 1/20/22 with discharged from hospital early A.M. with no injuries.

2. 100% Audit of all smoking residents have been evaluated, reassessed, and reviewed by Clinical Operations nurse and Registered Nurse Supervisor on each smoking resident's individualized plan of care with the Smoking Safety Evaluation forms completed on 1/20/2022. The Mississippi State Department of Health Licensure and Certification and Mississippi Attorney General 's Office were notified 1/20/22 at 10:15 P.M.

3. All staff inservices were initiated on 1/20/22 by the Executive Director, Registered Nurse Supervisor, and Staff Development Coordinator regarding facility smoking policy, fire drills,

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utilizing fire extinguishers, and when to evacuate residents. Staff will not be allowed to work until they have been in-serviced.

4. On 1/20/22 Fire watch was not warranted by the Maintenance Supervisor after consulting with the Brandon Fire Department who were present in facility. Maintenance Supervisor presented to facility to ensure smoking system was reset and facility was secured.

5. On 1/20/22 100% Room to room searches were completed by facility nurses and certified nursing assistants on all residents to retrieve all lighters and/or matches. All residents were checked for physical and emotional well being by Registered Nurse Supervisor with no injuries found.

6. An Emergency Resident's Smokers meeting was held on 1/21/222 with all smokers at 2:00 P.M. by Executive Director and the Director of Nursing regarding the smoking policy and amendment to the smoking policy for all residents not to have possession of lighters and or matches.

7. On 1/21/22 the Quality Assurance (QA) committee met to include Executive Director, Director of Nurses, Regional Clinical Operations nurse, Vice President of Operations, and Medical Director in regard to the fire and supervision for Resident #1. Residents environment was free from hazards when Resident #1 set fire to bed linens, bed mattress, oxygen concentrator, and privacy curtain with a cigarette lighter. The hazard jeopardized Resident #1 and all other residents and staff safety, health, and well being. One policy was reviewed -Smoking Policy.

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Smoking policy was revised to add Residents will not be all to possess lighters and/or matches.

8. Facility alleges relieving the immediacy of this Immediate Jeopardy (IJ) on 1/22/22.

The SA validations of the facility's Corrective Action Plans were completed by interviews, record reviews and observations on 1/28/2022 from 8:45 AM - 12:30 PM, with all staff in the building and via telephone interviews with staff that were scheduled to work first, second, and third shifts. Validations were conducted with interviews of 16 Licensed Practical Nurses (LPN's); Five (5) Registered Nurses (RN's); 1 Registered Dietitian (RD); six (6) dietary staff; four (4) business office staff; two (2) social workers; one Activities Director (AD); three (3) maintenance workers; 15 Certified Nursing Assistants (CNA's); four (4) Housekeeping staff; three (3) Laundry staff; one (1) Occupational Therapist; and three (3) Physical Therapist. Validations were completed through interviews, record review, and observations completed in the facility. There were approximately 63 facility staff members assigned to all three (3) shifts, including agency, and full time, that were interviewed for validations of the facility's Removal Plan/Corrective Action Plan.

SA Validations:

1. The State Agency (SA) validated through record review of the Nurses Progress notes for Resident #1 dated 1/20/22; the care plan update of Res #1 and the Hospital Progress Notes for Resident #1 all validating his injuries and assessments. Resident #7 and employee LPN #1 were interviewed and their release from the

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ER with no injuries were validated on 1/28/22 by the SA.

2. The SA validated through record review of the resident Smoking Evaluation for 33 smokers identified in the facility. The SA validated through interview with the ADM and by record review of the incident report that the SA and Attorney General's office was notified timely.

3. The SA validated through interviews of over 63 employees that they had all received the in-service training for the residents Smoking Policy, Fire Prevention; and had conducted fire drills prior to 1/22/22.

4. The SA validated through interview with the Director of Maintenance that he came to the facility on 1/20/22 and reset the fire alarm and began inservices with staff.

5. The SA validated through record review of the QI Team Room Review sheets that they had assessed all resident rooms on a daily basis. The SA also validated the QI Team daily searches with the QI /Staff Development nurse's interview. The Registered Nurse (RN #1) validated through interview that she assessed all residents after the fire on 1/20/22.

6. The SA validated through record review and interview on 1/28/22 with the DON that all resident smokers had been inserviced on the amendment of the Smoking Policy.

7. The SA validated through observation of the resident's smoking area and interview with the MD that the QA Team met and discussed the Smoking Policy and made and amendment to

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F 689	Continued From page 22 read: That no resident may possess a lighter and/or matches. The SA also validated the up dated Smoking Policy with the Regional VP through interview and record review.. 8. The SA validated through observation, interview, policy review, and record review completed on 1/28/22 that the facility had removed the immediacy of the Immediate Jeopardy (IJ) on 1/22/22 prior to the SA arriving at the facility on 1/26/22.	F 689		