Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Soundview II #4
Address: 30 Smith Graveyard Rd. Asheville, NC 28806
County: Buncombe
License Number: FCL011381

II. Date(s) of Visit(s): 08/01/2024
Purpose of Visit(s): Complaint Investigation
Exit/Report Date: 09/29/2024

Instructions to the Provider *(please read carefully)*:

In column **III (b)** please provide a plan of correction to address *each of the rules* which were violated and cited in column **III (a)**. The plan must describe the steps the facility will take to achieve and maintain compliance. In column **III (c),** indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or an Unabated B violation**, this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation**, this agency *may* submit an Administrative Penalty Recommendation for the violation(s). The facility has an opportunity to schedule an Informal Dispute Resolution (IDR) meeting within **15 working days** from the mailing or delivery of the Corrective Action Plan. If on follow-up survey the **Type A1 or Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty of up to $400.00 for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Unabated Type B, Citation* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent:** *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: 13G.0901(b) PERSONAL CARE AND SUPERVISION Rule/Statutory Reference: Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. Level of Non-Compliance: A1 Violation The findings are: Based on observations, interviews, and record reviews the facility failed to ensure 1 of 1 sampled resident (#1) was not smoking while wearing oxygen, resulting in a facility fire and injury to the resident (#1). Observation of the facility on 08/01/24 at 10:00am revealed: -There were large burn marks on the ground by the side door. -There were large burn marks noted on the side door threshold of the facility. -There were large burn marks about two feet long in the hallway of the facility. Review of Resident #1's current FL2 dated 01/18/24 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD), anxiety, depression, shoulder pain, posttraumatic stress disorder (PTSD), mobility impairment, and osteoporosis. -She was ambulatory and utilized a walker. -She was ordered 1 liter of oxygen continuously via nasal cannula. -She was admitted to the facility on 1/17/24. Review of Licensed Health Professional Support task form dated	☐ POC Accepted _____ *DSS Initials* Resident #1 has been discharged. Policy on Oxygen and Smoking Safely updated Safe smoking Assessments will be done upon admission to Identify any residents that may need to be supervised by staff while smoking. Safe smoking Assessments will be updated annually to identify any changes in resident condition that may indicate a need for additional supervision	

07/23/24 revealed staff competency in oxygen administration and monitoring.

Review of Resident #1's record on 08/01/24 revealed there was no care plan.

Review of facility Tobacco Use Policy dated 01/18/24 revealed:
-Resident #1 signed off on the policy as read in her admission packet.
-The policy included rule that "residents may only smoke outdoors."
- "Smoking in all other areas will be a violation of the policy and will result in immediate discharge notice."
- "When on the grounds of the facility all tobacco products must be disposed of in the proper receptable."
- "Tobacco use of any kind is not permitted in any facility vehicle nor is it permitted in gazeboes or surrounding garden areas. "

Review of the local Fire Marshal's report dated 7/10/24 revealed:
-Resident #1 was sitting outside of an exterior doorway smoking a cigarette while using oxygen via nasal cannula.
-There were no facility staff present while resident was smoking outside.
-The lit cigarette caused the oxygen to ignite, burning the oxygen tubing.
-Evacuation of facility residents and staff appeared to have been complete upon arrival.
-Emergency medical services (EMS) gave aid to Resident #1, for complaint of burn to right finger.
-Resident #1 was not using her oxygen when EMS arrived.
-Resident #1's oxygen saturation was 60% (normal range is 95-100% for a healthy person).
-Resident #1 was placed on oxygen at 4 liters via nasal cannula and her oxygen quickly rose to 95%.
-Resident #1 was transported to the hospital for further treatment.

Review of pictures of the scene provided by the Fire Marshal dated 07/10/24 revealed:
-Resident #1's walker was observed with dark scorch marks surrounding it on the ground.
-Parts of the oxygen tubing were present, and some of the tubing was burned.
-A cigarette butt was observed on the ground next to the scorch marks from the tubing.
-The threshold of the side entrance had a wide burn mark extended through the doorway.
-The burn mark was about two feet into the facility.

Interview with Resident #1 on 08/01/24 at 12:45pm revealed:
-She had smoked while using her oxygen on multiple occasions.
-The Administrator told her to put the tubing on the side of her walker.
-She did not think he had ever told her to turn her oxygen concentrator off while she was smoking.
- "After the fire started, I got up and went inside without telling anybody."

Additional Staff trainings will be done on safe use. oxygen and supervision of residents who smoke and use oxygen. Signage plaed by all exit doors to remind residents/visitors/staff of Safety regarding oxygen in designated smoking areas. All facility staff will recieve trainingannually on oxygen use and Safety.

-She had burns on her hands, but no burns on her face.
-The Administrator knew she smoked while using her oxygen, "he told me if he caught me again, he would kick me out."
-She does not recall being checked on by the staff while she was outside smoking.

Interview with a resident on 08/01/24 at 10:45am revealed:
-She had observed Resident #1 smoking while using her oxygen concentrator on multiple occasions.
-She had asked Resident #1 not to smoke with her oxygen on in the past.
-She had informed the staff and Administrator Resident #1 was observed smoking with her oxygen on.

Interview with a second resident on 08/01/24 at 10:16am revealed:
-Resident #1 smoked outside while using her oxygen "all the time."
-He asked the resident to stop smoking with her oxygen on and she refused.
-The staff tried to intervene, but the resident ignored them too.
-He did not want Resident #1 to return as to the facility from the hospital, "it's not safe with her here."

Interview with a third resident on 08/01/24 at 11:00am revealed:
-He had observed Resident #1 smoking while using her oxygen once.
-He was unsure if staff knew she smoked while using her oxygen.

Interview with the Supervisor-in-Charge (SIC) on 08/01/24 at 11:10am revealed:
-Resident #1 should have turned off the oxygen concentrator, left it in her room, and removed the cannula before smoking.
-She had spoken with the resident almost every day since Resident #1 was admitted in January regarding smoking outside with the oxygen on.
-She had informed the Administrator the resident had been smoking with the oxygen on multiple occasions since January.
-She had informed the Administrator about the most recent incident on 07/28/24.
-The Administrator came to the facility and spoke with Resident #1 to remind her of the rules regarding smoking.
-There were no additional safety precautions put in place.
-After the fire started, the resident ran into the house and didn't tell anyone.
-She was not asked by the Administrator to provide any extra supervision to Resident #1.

Interview with the Administrator on 08/01/24 at 1:40pm revealed:
-Resident #1 was observed by staff to be smoking while using oxygen when she moved into the facility.
-He told Resident #1 smoking while using oxygen was unsafe, and to stop smoking with oxygen multiple times including the last time on 07/28/24.
-He decided to give Resident #1 another chance to stop smoking while using oxygen.
-The facility did not initiate any additional checks or measures for

Resident #1 to prevent further smoking while using oxygen. The facility failed to ensure a resident was not smoking while wearing oxygen. The facility's failure resulted in serious injury to resident who sustained burns to her hands when using oxygen while smoking which constitutes a Type A1 violation. The facility provided a plan of protection in accordance with G.S. 111D-14 on 08/01/24 for this violation. DATE OF CORRECTION FOR THE A1 VIOLATION SHALL NOT EXCEED 10/29/2024		

IV. Delivered Via: Email	**Certified Mail #:**	Date: 11/07/2024
DSS Signature: Emily R. Weinstein		Return to DSS By: 12/03/2024

V. CAR Received by:	Administrator/Designee (print name): Jose Ortiz
	Signature: Date:
	Title: Administrator

VI. Plan of Correction Submitted by:	Administrator (print name): Jose Ortiz
	Signature: Date: 12-3-24

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ ***POC Not Accepted***	By:	Date:
Comments:		
☐ ***POC Accepted***	By:	Date:
Comments:		
VIII. Agency's Follow-Up	By:	Date:
	Facility in Compliance: ☐ Yes ☐ No	Date Sent to ACLS:
Comments:		

** For follow-up to CAR, attach Monitoring Report showing facility in compliance.*