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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stone Valley	**123 Main St,. Anywhere, US 66000**

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F 689 SS=G	§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, staff interview, resident interview, clinical record review, facility document review, and during a complaint investigation, the facility staff failed to ensure an environment free of accident hazards and failed to ensure adequate supervision to prevent accidents for three of 32 residents (Residents # 64, # 38, and # 88); failed to ensure adequate supervision for one of 32 residents (Resident # 145), which resulted in harm and failed to ensure for one of 32 residents that sunscreen was applied to the top of the foot area for the prevention of sunburn resulting in a blistering sunburn which had to be surgically debrided (procedure requiring local anesthetic and removal of dead skin tissue with a scalpel) resulting in harm for Resident # 347. 1. The facility staff failed to ensure safety and supervision for Resident # 145 for access to the smoking area, as a result the resident fell in koi pond and was found by another resident;	F 689	a. Resident was removed from outside area, wet clothes removed, and dried, and sent to local hospital for evaluation. courtyard was blocked off immediately to limit access by other patients. b. Resident #347 is no longer a resident of our facility. c. Resident #64s Vape device is now properly secured at receptionist desk or designated area. d. Pull cord in restroom of resident #38 has been replaced. e. Pull cord for resident #88 has been replaced. 2. a. All residents who go outside unattended are at risk. b. All residents who go outside in the sun are at risk for sunburn. c. An audit of all residents who smoke was conducted by facility DON on	4/4/18

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F 689	Continued From page 1 Resident # 145 was sent to the hospital and treated for hypothermia, partial seizures, and Influenza B (FLU). The resident returned to the facility 8 days later. This resulted in harm. 2. Resident # 347 sustained a blistering sunburn to the tops of both feet which had to be surgically debrided weekly in excess of 88 days resulting in harm. 3. The facility failed to ensure Resident # 64's Vape device and vaping liquids were properly stored at the Nurse's Station, and in accordance with the plan of care, when not in use. 4. Resident #38 had no pull cord on the emergency call light in the resident's restroom. 5. Resident #88 had no pull cord on the emergency call light in the resident's restroom. Findings include: 1. The facility staff failed to provide adequate supervision to Resident # 145 for access to the smoking area, which resulted in the resident falling into a koi pond. The resident was found by another resident and was sent to the hospital for treatment. This resulted in harm. Resident # 145 was admitted to the facility on 01/31/18. Diagnoses for Resident # 145 included, but were not limited to: Paranoid schizophrenia, anxiety disorder, depression, Vitamin D deficiency, symbolic dysfunction, bipolar disorder, and weakness. The resident discharged out of the facility on 02/07/18, following a fall into the koi pond in the smoking	F 689	3/9/2018. It was determined that no other residents utilize Vape devices. d. A facility wide audit was conducted on 3/13/2018 by maintenance personnel to ensure pull cords were in place. No other issues identified. 3. Maintenance personnel have installed new LED lighting around koi pond, installed temporary fencing around pond with permanent fencing to be installed once delivered, locks were installed on door to be locked during dark hours, and upgraded flood lighting installed. Maintenance personnel to inspect pond area weekly to ensure interventions are in working order. In-service training of facility staff by DON and designee regarding the monitoring of residents who are designated as supervised smokers initiated 3/8/2018. Facility staff in-service training initiated on 3/8/2018 by DON and designees regarding communicating work orders to maintenance staff regarding maintenance needs of residents including, but not limited to, the installation of pull cords in restrooms, etc.. All residents identified as smokers were in-serviced on 3/6/2018 by facility DON and Social Services Director regarding smoking policy and ensuring that Vape and other smoking materials are locked up in accordance with facility policy. Facility activities staff were in-serviced on 3/9/2018 by facility DON or designee regarding availability and utilization of sunblock during organized outside activities. A audit of facility smoking area containing koi pond to be completed by facility maintenance personnel five times	

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AVANTE AT LYNCHBURG	**123 Main St. Anywhere, US 66000**

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F 689	Continued From page 2 area and was readmitted to the facility on 02/15/18. The most current MDS (minimum data set) was a discharge return anticipated/14 day admission (completed on 02/13/18), the ARD (assessment reference date) was 02/08/18. Section C (Cognitive Patterns) of this MDS was blank. There was no cognitive information documented on this resident. This MDS assessed the resident as requiring supervision with one person physical assist for bed mobility/transfers and as requiring supervision with ambulation (no physical help), the resident was additionally assessed for locomotion on/off the unit as 7/0 (indicating that this activity only happened once or twice without support from staff), the resident was assessed for extensive assistance from staff for dressing, toileting and hygiene with one person physical assist. This MDS assessed the resident as 'not steady, but able to stabilize without human assistance" for moving from a seated to standing position, walking, turning around, and surface to surface transfer. The resident was coded on this MDS as a current smoker and using a w/c for ambulation/mode of transportation. A complaint investigation was conducted on 02/20/18 through 02/23/18. An allegation within the complaint alleged that the resident fell into the koi pond, was unable to get out and was found by another resident and subsequently went to the hospital for treatment. On 02/20/18 at approximately 10:30 a.m., a brief	F 689	a week for a period of 30 days to ensure that fencing and other safety measures put in place as part of POC dated 2/15/2018 are in working order. A weekly audit of facility organized outdoor activities to be completed by Activities Director for a period of 90 days to ensure availability and implementation of sunblock. An audit of facility smoking box to be completed three times a week for a period of 30 days by facility DON or designee to ensure Vape devices and vaping liquids are properly stored. Facility maintenance personnel to audit facility resident restrooms on a weekly basis for a period of 60 days to ensure pull cords are installed and operational. 4. The results of all audits to be brought to monthly Quality Assurance and Performance Improvement meeting for review and revisions as the committee determines.	

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entrance conference was conducted with the administrator who was made aware of follow up from FRIs (facility reported incidents) and that there were complaints. The administrator stated that he would provide information and follow up for FRIs and information related to the incident concerning Resident # 145. The administrator provided a list of smokers (supervised and unsupervised) and an 'updated' (as of 2/20/18) supervised smoking assignment document.

Resident # 145 was observed multiple times during the survey process in his room in bed and in the hall area in his w/c (wheel chair), the resident was observed as slow for mobility and response when spoken to.

On 02/22/18 at 8:40 a.m., the smoking area was observed, no residents were in the area at this time. The door leading to the outside courtyard was not locked and when opened, no alarms of any type were seen or heard to evidence notification to staff that the outside area had been accessed.

On 02/22/18 at 9:40 a.m., the resident was observed in his w/c in the smoking area with staff.

Resident # 145's clinical record was reviewed. A smoking assessment dated 02/01/18 (timed 10:14) documented that the resident was able to call for help if a lit cigarette ash or cigarette falls on the person and was receiving medications with the potential to cause sedation, did participate in the education and care planning regarding smoking activities and was documented to smoke independently. The assessment additionally documented that the resident may smoke unsupervised in designated

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areas.

An admission nursing assessment dated 02/01/18, documented that the resident had slow comprehension and was oriented to person and was a current smoker and that the resident was oriented to the smoking rules. This assessment was signed completed on 02/08/18, the day after the resident's fall.

The resident's Kardex dated (01/31/18) was reviewed and documented that the resident is 'dependent' upon staff for smoking.

A fall risk assessment completed on 02/01/18 documented that the resident was a high risk for falls and had mild/moderate impairment in cognitive skills. This assessment also documented that the resident used a leg brace, w/c, walker and cane and that the resident wears glasses, but did not have them with him.

An elopement assessment dated 02/01/18 gave the resident a score of 12 (total score of 10 or greater, the resident should be considered at risk).

Resident # 145's physician's orders were reviewed, the resident did not have a physician's order to smoke, either assisted or unassisted.

Progress notes were then reviewed and documented the following:

02/01/18 [12:49 a.m.] - '...seemed to enjoy being at this facility...especially since he is able to smoke outside...'

02/01/18 [3:44 a.m.] - '...Resident ambulates with

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F 689	Continued From page 5 cane...no behaviors...' 02/01/18 [10:24 a.m.] - "...Initial admission data collection review...SW [social worker]...Resident was laying on top of the bed, fully dressed with hood of coat on his head with his feet and legs hanging down and drooling...full code...resident is single...his half brother...and sister...visit if "I'm not drinking"...comments on education...states he has a doctorate from [name of a university] and worked at [name of company] 'I was a supervisor' Resident stated he is an Admiral [military history]...Medical and Psychiatric History: 'I have a clean track record and I am accountable'...Resident stated he does well with change and likes being at this new place "as long as he gets his cigarettes on time"...During the resident interview he expressed, "I want to retire and monitor at your residence"...." 02/02/18 [4:18 p.m.] - 'SW [social worker]...met face to face with resident...alert yet presents with confusion and appears to need psychiatric evaluation based upon his responses which indicate need. Resident is a smoker and states everything will be fine as long as he gets his cigarettes on time...will monitor follow progress.' 02/04/18 [2:37 p.m.] - "Behavior: PATIENT SEEN SMOKING IN HALLWAY BY STAFF, AND X 5 [five] CIGARETTE BUTTS FOUND UNDERNEATH HIS BED, AND X 2 [two] IN THE CLOSET...patient redirected cigarette put out, nurse along with other staff members stressed the importance of not smoking in the facility or bring [sic] cigarette butts from outside, patient has a lighter and will not allow it to be locked away...patient will be monitored Q [every] hour X [times] 24 HRS."	F 689		

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F 689	Continued From page 6 The resident's MARs (medication administration record) were reviewed and revealed a behavior observation sheet that documented the resident was exhibiting 'wandering/pacing' type behaviors on the evening shift on 02/04/18. 02/05/18 [1:26 p.m.] A note by the SW documented, '...referred to psychiatrist due to responses on initial admissions assessment.' No physician's orders were found for a psych consult and/or any documentation that the physician was made aware of any of the above information. 02/05/18 [5:19 p.m.] [Physician's Progress Note] documented by the NP [nurse practitioner] - '...paranoid schizophrenia... There are no notes that I could find about why patient is at [name of facility]...tobacco abuse... outside smoking used cigarettes [sic]...slow cognition... slow speech...oriented to self only...Plan: ...Resident requires nursing facility services for safety...' None of the information regarding the resident smoking in the hall, found with cigarettes in his room, making inappropriate responses (per the SW) were addressed by the NP. 02/07/28 [7:34 p.m.] '...found outside lying in pond, patient was lying on his back, his face was up...Patient non-compliant and has been going back and forth outside all day night and staff has redirected him X [times] 4 with effective results...difficulty talking and soak [sic] and wet from pond, dry clothing applied and wrapped with several blankets...send to ER [emergency room] for further evaluation...' The resident was sent to the hospital on 02/07/18 between 7:15 p.m. and 7:30 p.m.	F 689		

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F 689	Continued From page 7 According to the hospital H&P (history and physical) dated 02/08/18, the resident was admitted and treated at the hospital for, 'hypothermia, developed a fever during the night, found to have influenza [flu], and also now with concern of a partial complex seizures [sic]...apparently smokes a few cigarettes per day. He likes to be outside. He went outside apparently yesterday evening...ambulates with a cane as he has problems with the hip...suffered a fall and fell in the pond...apparently there...and could not get out, was there for, he says for about an hour or so...hypothermic...positive influenza B...he apparently became poorly responsive for a short time and there were twitching type moments of his right upper extremity...concerned, this could represent partial complex seizures..." An addendum progress note from the hospital dated 02/08/18, documented that the patient was interviewed and examined and the resident stated he slipped into the pond and this was not an attempt to harm himself. The resident's CCP (comprehensive care plan) was reviewed and documented, "...01/31/18...Unsafe Smoking: At risk for injury related to unsafe smoking...Will safely smoke at designated times, in designated areas with supervision of staff and have no smoking injuries or incidents...assist [name of resident] as needed to designated smoking area at designated times and supervise smoking...ensure [name of resident] does not leave designated smoking area with smoking materials...facility smoking policy will be reviewed with resident...will be instructed, and reminded as indicated that any smoking materials (cigarettes, cigars, pipes, matches,	F 689		

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lighters) are to be turned into staff for management and dispensing...Smoking assessment to be completed on admission, quarterly and with any significant change in condition..."

Resident # 145 only had one smoking assessment completed (02/01/18); the resident did not have another smoking assessment completed upon readmission to the facility on 02/15/18.

An initial/interim care plan could not be located for Resident # 145 for Falls. A fall risk assessment was completed on 02/01/18 and identified the resident as high risk for falls. The resident's CCP did not address falls and/or safety related to falls at all and was not developed until 02/08/18, after the resident had fallen in the pond in the smoking area.

The 'supervised smoking assignment' sheet presented by the administrator dated 12/11/17, with a hand written entry [update date] of 2/20/18 documented, "...Supervised smokers are allowed two cigarettes per 15 minute time period. Smokers must return all lighters, matches, etc. to the lockbox when finished smoking...New residents must be supervised until assessed for unsupervised privileges...all supervised smokers must be accompanied by a family member or an employee...smoking location for residents will be in the courtyard..."

The facility's "Smoking Protocol" was presented and documented, "While a resident at this facility, residents who wish to have smoking privileges may be allowed to do so subject to the following rules: "1. Prior to, or upon admission, resident

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shall be informed about any limitations on smoking... 2. Residents who smoke will have a smoking assessment done to determine independent or dependent smoking privileges... assessment will review cognitive ability, manual dexterity, and mobility... all residents that desire to exercise smoking... will be assessed to determine their smoking safety awareness... smoking assessments will be done as part of the admission process, quarterly, or when reassessment is indicated... the staff shall consult with the Attending physician and the IDT [interdisciplinary team] to determine any restrictions on a resident's smoking privileges... any smoking related privileges, restrictions and concerns shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues... facility may impose smoking restrictions on residents at any time if it is determined that the resident cannot smoke safely... The staff will review the status of a resident's smoking privileges periodically, and consult as needed with the Director of Nursing Services, IDT or attending physician... All smoking materials (cigarettes, cigars, e-cigarettes, etc.) will be kept at the nurses station or a facility designated area. Smoking materials will only be given to residents that have been determined to be safe/independent smokers during the designated smoke times... Residents determined to be "Supervised or Assisted Smokers" will receive their smoking material... by the staff member assigned to monitor the smoking area and those materials will be returned by that staff member to the... area for storage... Violations of this protocol or the smoking contract will bring restrictions of smoking privileges or possible discharge from the facility if behaviors present a danger to self or

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others. Actions such as smoking in non-designated areas, allowing any other resident to use, borrow, buy or have access to smoking material, or any other behavior considered to exhibit poor safety awareness may result in revocation of smoking privileges... Smoking restrictions shall be strictly enforced in all nonsmoking areas... Smoking shall be prohibited at all times in any room, storage area, or any other area where oxygen, flammable liquids, materials, or combustible gases are in use or stored... Smoking is prohibited in public areas or where groups of people frequently gather... The facility will have designated smoking areas. Designated smoking areas may be outside weather permitting... Staff members and volunteer workers shall not purchase and/or provide any smoking articles for residents unless approved by the charge nurse... The facility may check periodically to determine if residents have any smoking articles in violation of smoking policies...."

The administrator was interviewed on 02/22/18 at approximately 8:15 a.m. the administrator was asked for the investigation information for Resident # 145. The administrator presented a folder with information and statements regarding the incident. The investigation information was reviewed and the documentation included, but was not limited to the following:

A statement by LPN (Licensed Practical Nurse) # 30 documented in summary, that Resident # 145 was observed just prior to supper being argumentative with the nurse at the nurse's station at around 7:00 p.m. on 02/07/18 and that it wasn't long after that a page came over for all nurses and CNA's to go to the courtyard.

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A statement by LPN # 12 documented that the resident was last seen around 6:00 p.m. the resident was seen ambulating using a walker around the facility and that the patient had been redirected four times prior to the incident, the resident kept going outside and continued to go back and forth outside in the rain and he would just sit at the table. At about 7:00 p.m., page overhead stated a patient is down in the courtyard.

A statement by OS (other staff) # 7 documented that at 7:10 p.m. on 02/07/18 a resident came to the receptionist desk and stated that someone had fallen into the pond in the courtyard, it was pitch black dark outside and she [OS # 7] couldn't see anything, [she] took a few steps and saw something floating in the pond, [she] ran back inside and paged for immediate assistance from nurses and CNA's to the courtyard, Resident # 145 was pulled from the pond after that.

A statement by a resident documented that it was dark and after dinner when the incident happened, this resident went outside via the courtyard door and kept hearing something, but didn't see anything because it was so dark, this resident made a loop around the pond to come in and that's when [this resident] saw someone in the pond on his back, [this resident] told him [Resident # 145] that he would go get help and went and told the person at the receptionist desk, everything got hectic and staff got him [Resident # 145] out of the pond and called 911.

On 02/22/18 at 9:59 a.m., LPN (Licensed Practical Nurse) # 44 was interviewed regarding Resident # 145 and was asked if the resident was

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supposed to be supervised for smoking and/or going outside, the LPN stated, "Always."

An interview was attempted with Resident # 145 on several occasions, which the resident declined.

02/23/18 at 8:46 a.m., Resident # 19 was interviewed regarding Resident # 145 falling into the pond. Resident # 19 stated that it was around 7 or 8 at night when it happened. The resident was asked if this resident was supposed to be supervised in any way. Resident # 19 stated, "he was supposed to." Resident # 19 was asked if he was supervised, the resident stated, "No." Resident # 19 was asked how he knew that, Resident # 19 stated, "Everybody knows that." Resident # 19 stated that when you come here you need to be assessed and stated that Resident # 145 snuck out and fell in the pond. Resident # 19 stated that it rained all that day (when the fall happened) and he (Resident # 145) sat right there (pointing to spot) in the pouring rain.

This surveyor and Resident # 19 went to the courtyard area. The resident used the handicap accessible push button to open the door, the door opened giving access to the courtyard. No alarms/lighting or any type of notification and/or alerting system was seen or heard. It was cloudy, overcast with a light misting of rain and cool temperature. The table and chairs were wet, this surveyor wiped a chair off and sat down, the resident was in a w/c. Resident # 19 was asked if the door was locked to the outside the day the Resident # 145 fell, the resident stated, no-but they've been locking it at dusk now. Resident # 19 stated that he didn't like that because he has

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insomnia and likes to go out to smoke when he can't sleep and was assessed to safely smoke alone; now he states that he can't do that because the guy fell in the fell in the pond. The resident stated that he (Resident # 145) had been going in and out most of the evening, in and out of the rain.

On 02/23/18 at approximately 10:45 a.m., the complaint allegations for Resident # 145 were reviewed with the administrator and DON (director of nursing) in a meeting with the survey team. The administrator and DON were made aware of the serious concerns regarding Resident # 145's fall into the pond, the lack of safety awareness on the resident's part, as evidenced by smoking in the hall way, keeping cigarette butts in his room and closed with failure to return a lighter to staff, the facility staff failing to implement interventions for Resident # 145 for violating the smoking policy and failing to implement interventions and provide supervision for Resident # 145 related to falls.

The administrator stated in summary, 'Are you saying that a resident can't go out to the courtyard without being supervised even if they aren't smoking.' The administrator was made aware that is not what the survey team stated in any way. The administrator was again made aware that Resident # 145 was identified (by facility staff) as a risk in several care areas and that those identified concerns for this resident were not addressed or acted upon appropriately to ensure a safe environment and to prevent accidents for Resident #145, and all other residents.

No further information and/or documentation was

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presented prior to the exit conference on 02/23/18 at 12:45 p.m., to evidence that the facility staff provided a safe environment and appropriate supervision for Resident # 145 for the prevention of accidents, which resulted in harm.

This is a complaint deficiency.

2. Resident # 347 sustained a blistering sunburn to the tops of both feet which had to be surgically debrided weekly in excess of 88 days resulting in harm.

Resident # 347, a closed record review, was admitted to the facility 10/11/12 with a readmission date of 1/3/18. Resident # 347's diagnoses included, but were not limited to: acute kidney failure, chronic kidney disease/severe stage four, diabetes, and high blood pressure.

An MDS (minimum data set) quarterly review dated 6/7/17 had assessed the resident with moderate impairment in cognition with a total summary score of 12 out of 15.

The clinical record was reviewed 2/21/18 at 7:30 a.m. Nurses' notes were reviewed, and a note dated 5/18/17 documented "Resident complained of feet itching and asked nurse to check her feet. I observed open areas (1 on each upper foot). Wound nurse checked both and put treatment in place. Small blisters noted above areas. Resident had legs crossed and was rubbing them against each other. 98.2-72-156/76 (sic). MD notified. Called RP (responsible party) and (family member) with RP number not in service.

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(Family member's) mailbox full. Areas cleansed with normal saline, xeroform gauze applied with cover dressing. Dressing will be changed every other day. Resident advised not to rub feet/legs together but to let staff know when she is itchy." The note was signed by LPN (licensed practical nurse) # 2.

The clinical record did not include any other nurses' notes about the areas to the tops of the resident's feet. The next documentation located was an acute visit by the facility nurse practitioner (NP) dated 5/23/17 which documented ".....I was asked to see (name of resident) today by nursing due to 2 wounds on top of her feet.....she said they do hurt. She denies chest pain, shortness of breath....She does have wounds on both tops of her feet. It looks like it blistered up from whatever has happened and then has opened up. They do have Vaseline gauze on there at the time and they are covered. No drainage noted..... PLAN: I have asked the wound nurse and wound doctor to please see her today...."

The "Wound Care Specialist Evaluation" forms were then reviewed. The first evaluation form, dated 5/23/17 documented "At the request of (name of physician), this 76 year old female was seen and evaluated today...." The evaluation form included documentation of surgical excisional debridement of the dorsal (top of foot) wounds of both feet. The treatment notes initially described the wound as an arterial wound; however, on the treatment evaluation form dated 6/20/17, an area marked "Additional information" documented "After investigation of events prior to my first exam it was noted by CNA caring for patient and the patient's nurse (name of LPN # 2) that day that this patient appeared to have

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sunburn on both feet dorsal surface. Wounds were red with blistering that day then note of necrosis the following day. Discussed case with wound care nurse, interim DON (director of nursing), and NP. All are in agreement that wounds are secondary to sun exposure."

The treatment notes, including weekly debridement, were reviewed to reveal the left foot healed 7/25/17, and the left foot healed 8/22/17. The wounds required treatment, including the weekly surgical debridement, in excess of 88 days.

Further review of the clinical record revealed skin assessment sheets, dated 5/3/17, 5/10/17, 5/17/17 were blank, with the exception of an assessment dated 5/31/17 prior to the resident going to the hospital for an unrelated event.

The assessment sheet(s) included "A. Skin Conditions. a. Skin Condition (list all areas NEW or OLD (sic)." Under this area were blocks where information was to be documented including site and description. Under "site" was documented "Other (specify)." Under "description" was documented "Tops of both feet. Dressings present. Treatment was in place before patient went to hospital." Under "b. New Areas Noted?" was marked "no." The rest of the assessment included "c. List the areas noted above which are new. d. Physician notified and Treatment Ordered for new areas? d.1. Name of Family Member Notified and Date. e. Referral made to wound care nurse for new areas?" All areas "b" through "e" had options of "Yes" or "No" to be marked, and the areas were not marked. Skin assessment sheets for June 2017 were also reviewed and were also blank with no

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assessments completed.

The care plan for May 2017 and June 2017 were reviewed, and a Focus area updated 5/22/17 documented "Bilateral open areas on top of both feet (3 degree burns). Under "Goals" was documented "(name of resident) will have no complications related to (SPECIFY skin injury type) (sic) of the (SPECIFY location) (sic) through the review date." The skin injury type and location was not documented. "Interventions" for the focus area included "Educate resident/family/caregivers causative factors and measures to prevent skin injury..... Follow facility protocols for the treatment of injury.....Observe/document location, size and treatment of skin injury. Report abnormalities, nursing failure to heal, signs/symptoms of infection, maceration, etc. to MD....."

On 2/21/18 at 10:45 a.m. LPN # 2 was interviewed about the nursing note dated 5/18/17. LPN # 2 stated "I looked at her feet when she complained of them itching. We had a picnic here at the facility that day and we had put sunscreen on all the residents going outside to the picnic. We made sure faces, arms, etc. had sunscreen on them; I guess we didn't think about her feet. She had on slipper type shoes, and that was the pattern of the sunburn; the very tops of her feet had been exposed. We got her seen right away by the nurse practitioner and wound nurse; they started treatment."

On 2/21/18 at 4:00 p.m. an interview with the DON, who was identified as the interim DON when the incident occurred, and the regional nurse consultant was conducted. The DON and regional nurse consultant were asked about the

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lack of nursing documentation, and lack of documentation on the skin assessment sheets. The regional nurse consultant stated "I believe the computer system was down that day, which is why there was no skin assessment sheets for that day. It would have been entered as a nursing note scanned into the system."

The regional consultant was then asked how long the system was down, as there were no skin assessments or nurses' notes regarding the wounds with the exception of 5/18/17, and a skin assessment form dated 5/31/17. The regional nurse consultant stated she was not sure how long the system was down, but thought it was down for about a day.

The DON was asked about the lack of documentation, and she stated "There should have been nursing notes. And we have identified the skin assessment forms as an area needing improvement; those should have been filled out as well." The DON further stated the facility had done a QAPI (quality assurance program improvement) since the incident to include orders for staff to apply sunscreen as needed for all residents going outside during the months a sunburn could be acquired. She also stated an education on skin assessment sheets was ongoing. The DON was also asked about the reference to a third degree burn on the care plan. She was asked if there was a definition of third degree burn, and if the resident had been diagnosed with a third degree burn.

On 2/22/18 at 7:44 a.m. the administrator and DON were informed of the above findings, and the possibility of a harm level citation. The administrator and DON had no comment.

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F 689	Continued From page 19 On 2/23/18 at 8:00 a.m. the DON informed this surveyor it was not clear why the sunburn was referred to as a third degree burn; there were no physician notes or diagnoses for a third degree burn. No further information was provided prior to the exit conference. THIS IS A COMPLAINT DEFICIENCY. 3. The facility failed to ensure Resident # 64's Vape device and vaping liquids were properly stored at the Nurse's Station, and in accordance with the plan of care, when not in use. Resident # 64 in the survey sample, a 69 year-old male, was admitted to the facility on 2/3/17 with diagnoses that included chronic pain syndrome, anemia, depressive disorder, contracture of the left ankle, bacteremia, right below the knee amputation, anxiety disorder, and generalized muscle weakness. According to the most recent Annual Minimum Data Set, with an Assessment Reference Date of 1/27/18, the resident was assessed under Section C (Cognitive Patterns), as being cognitively intact, with a Summary Score of 15 out of 15. During the orientation tour at 10:30 a.m. on 2/20/18, the resident was observed just inside the door of his room, seated in his wheelchair. While the surveyor engaged the resident in conversation, a Vape device was observed on the resident's night stand, located next to the door of the room. Asked if he vaped, Resident # 64 said, "Yes. I never smoked, but I do vape."	F 689		

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F 689	Continued From page 20 At 10:15 a.m. on 2/23/18, Resident # 64 was observed in the facility's Courtyard, seated in his wheelchair. At the time of the observation, the resident was engaged in vaping. When asked how much nicotine he used in his vape mixture, he said, "I use 3 milligrams." When he finished vaping, the resident placed the Vape device in his lap, wheeled himself out of the Courtyard, through the Day Room, and into the hallway where he joined other residents waiting to enter the Dining Room to play Bingo. When the Dining Room door was opened, Resident # 64 entered along with other residents to play Bingo. At approximately 10:20 a.m. on 2/23/18, the surveyor went to the resident's room where two containers of vaping liquids were observed on a small table next to his night stand. The first container was labeled "KEEP IT 100 KRUNCHY SQUARES, 3 mg (milligrams) (0.3%), 100 ml (milliliters) (3.38 FL OZ) (fluid ounces)." The following warning also appeared on the label, "WARNING: This product contains nicotine. Nicotine is an addictive chemical." The second container was labeled, "Gorilla Vapes." There was a space on the label for the flavor of the liquid, but the writing was smudged and unreadable. The label also included the following entry, "This product may contain nicotine, as addictive substance known to the State of California to cause birth defects or cancer." At 10:25 a.m. on 2/23/18, LPN # 3 (Licensed Practical Nurse), the Charge Nurse on the unit where Resident # 64's room was located, was asked about the storage of his vaping supplies.	F 689		

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"He keeps them in his room," LPN # 3 said. "We (the nurses) have questioned why he is allowed to keep them in his room, but apparently someone gave him permission."

Review of Resident # 64's care plan, dated 1/23/18, revealed the following problem, "(Name of resident) has a Vape smoking device and is safe to use this unsupervised." The goal for the problem was, "(Name of resident) will be maintained in a safe environment, free from injury related to a Vape device through this review."

Interventions for the stated problem were:
"(Name of resident) will use his Vape device in designated smoking areas only.
Smoking assessment will be done on admission, quarterly, annual, sig (significant) change and PRN (as needed) to determine safety during smoking.
Smoking supplies will be kept in a locked box at the Nurse's Station. Supplies will be distributed by nursing staff."

4. The emergency call light in Resident #38's bathroom was missing a pull cord.

Resident #38 was admitted to the facility on 5/25/17 with a re-admission on 12/11/17. Diagnoses for Resident #38 included high blood pressure, diabetes, seizures, bipolar disorder, pneumonia and depression. The minimum data set (MDS) dated 12/21/17 assessed Resident #38 as cognitively intact.

2/22/18 at 11:15 a.m., Resident #38's bathroom was inspected. The emergency call light next to the toilet was missing a pull cord. The light had a

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F 689	Continued From page 22 switch but no pull cord attached. On 2/22/18 at 3:24 p.m., the licensed practical nurse (LPN #3) caring for Resident #38 was interviewed about the missing safety cord. LPN #3 stated she was not aware of the missing pull cord on the call light. On 2/22/18 at 3:48 p.m., the maintenance director was interviewed about the missing pull cord on the call light. The maintenance director stated he was not aware of the missing pull cord. The maintenance director stated all staff members were supposed to monitor resident safety devices and write work orders for items needing repair. These findings were reviewed with the administrator and director of nursing during a meeting on 2/22/18 at 5:25 p.m. 5. The emergency call light in Resident #88's bathroom was missing a pull cord. Resident #88 was admitted to the facility on 5/28/13 with a re-admission on 5/31/14. Diagnoses for Resident #88 included heart failure, dementia, arthritis and deep vein thrombosis. The minimum data set (MDS) dated 2/9/18 assessed Resident #88 with severely impaired cognitive skills. On 2/22/18 at 11:15 a.m., the bathroom in Resident #88's room was inspected. The emergency call light next to the toilet was missing a pull cord. The light had a switch but no pull cord attached.	F 689		

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F 689	Continued From page 23 On 2/22/18 at 3:24 p.m., the licensed practical nurse (LPN #3) caring for Resident #38 was interviewed about the missing safety cord. LPN #3 stated she was not aware of the missing cord on the call light. On 2/22/18 at 3:48 p.m., the maintenance director was interviewed about the missing pull cord on the call light. The maintenance director stated he was not aware of the missing pull cord. The maintenance director stated all staff members were supposed to monitor resident safety devices and write work orders for items needing repair. These findings were reviewed with the administrator and director of nursing during a meeting on 2/22/18 at 5:25 p.m. Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 689		