STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105012	A. BUILDING _____ B. WING _____	**03/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEALTH AND REHABILITATION CENTRE AT DOLPHINS VIEW	**1820 SHORE DR S SOUTH PASADENA, FL 33707**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review the facility failed to provide appropriate and sufficient supervised safe smoking in accordance with their safe smoking policy and resident assessments for four (Residents #4, #5, #8, and #7) out of seven sampled residents, failed to ensure that residents who had been documented to require smoking aprons when smoking were wearing them while smoking unsupervised for three (Residents #4, #7, and #5) and failed to limit accessibility of lighters in accordance with their safe smoking policy for seven (Residents #4, 5, 6, 7, 8, 9, and 10) out of seven sampled residents. Findings Included: At 5:54 PM on 03/09/2020 Resident #4 was observed actively smoking while seated in a wheelchair on the ramp directly outside of the facility therapy gym exit door. There were no smoking signs posted in the area where she was smoking and there were no staff present supervising her smoking. At 6:14 PM the facility Nursing Home Administrator (NHA) was interviewed and stated he was aware that Resident #4 had been smoking unsupervised earlier in a non-smoking area and stated that all resident smoking at the facility was to occur only at scheduled times, in designated smoking area, with staff supervision. At 6:16 PM while interviewing the NHA about smoking, Resident #5 was observed seated in a wheelchair actively smoking in the designated smoking area without any staff present. She was not wearing a smoking apron. The NHA intervened with the resident and redirected her to cease smoking and reminded her of the facility smoking policy. Resident #6 was outside in the patio area nearby and the NHA requested for the facility Director of Nursing (DON) to investigate whether either resident had a lighter. The DON was observed intervening with Resident #6, resident was heard yelling loudly and the DON later reported that the resident had a lighter and was upset about turning it in. At 6:30 PM on 03/09/2020 a supervised smoking period began in the designated smoking area. Two staff members were present, and Staff B, Certified Nursing Assistant was observed wheeling a plastic bin into the area. Staff B was interviewed about the smoking process. She reported there was a facility schedule of supervised smoking periods and that the facility policy was that residents were not permitted to smoke on the property except during scheduled smoking times with staff supervision. She revealed the contents of the plastic bin which included individual plastic containers, each labeled with a resident's name, which held smoking materials belonging to each resident. Staff B stated that residents were not allowed to have lighting materials in their possession but could keep their cigarettes in their possession if they chose to. She stated that as the smoking supervisor, she was responsible for ensuring that residents were smoking safely, that required measures such as smoking aprons were applied, and that residents returned all lighting materials. Staff B revealed that smoking aprons were kept in the plastic bin for issue to residents who required them, and revealed a document tiled, updated smoking list dated 02/21/2020 which revealed that Residents #4, #5, and #7 required smoking aprons. At 7:40 PM on 03/09/2020 during a facility tour with the NHA, Resident #5 was observed actively smoking in the patio area outside of the therapy gym. There were no staff present supervising her, and she was not wearing a smoking apron. Nearby, Resident #7 was also actively smoking. He was wearing a hospital gown and was not wearing a smoking apron. There were no staff present supervising him. The NHA intervened with the residents at 7:41 PM and redirected them that they were not to be smoking unsupervised. The residents reported that they had gotten their cigarettes lit from another resident who had a lighter. The rest of the outdoor patio area was searched and Resident #10 was found in another area of the patio. He was not actively smoking, however when questioned by the NHA he admitted that he had a lighter and had given it to the other residents to light their cigarettes. Resident #10 gave the lighter to the NHA at 7:51 PM. Resident #10 confirmed that he was aware of the facility smoking policy and that he was not supposed to have lighting materials in his possession. At 8:09 PM Resident #4 was observed smoking unsupervised sitting in her wheelchair on the ramp directly outside the therapy gym patio exit door. There were no smoking signs posted where she was smoking. Resident #4 was not wearing a smoking apron. Resident #8 was observed passing a lighter with Resident #4 and then observed nearby holding a cigarette that appeared to have been lit and put out. The facility NHA intervened with Resident #8 in order to get the lighter and the resident became agitated and denied having a lighter. At 7:45 PM on 03/09/2020 the facility DON was interviewed. She reported that she had initiated resident and room searches earlier in the evening after discovering that Resident #4 had been smoking unsupervised. She reported that she had assigned resident searches to herself and resident and room searches to a team of staff. She reported the purpose of the searches was to find and confiscate lighters. She reported that Resident #9 had admitted to giving a lighter to Resident #6 which Resident #6 eventually gave up with intervention. She stated Resident #4 had been found to have a lighter but would not say where she had gotten it, and Resident #5 had been found to have a lighter but would not say where she had gotten it. The DON confirmed that it was the facility policy that residents only smoke at designated smoking times with staff supervision and that they not keep lighting materials in their possession. She stated, we do wind up finding lighters. She reported that safe smoking assessments were conducted for all residents who smoked upon admission, quarterly, and at discharge. At 8:21 PM on 03/09/2020 additional interview was conducted with facility NHA, DON, and the Regional Vice President of Operations (VP). The DON reported that the process for resident or room search was to first gain their permission for the search and give the resident the opportunity to disclose and give up any lighters prior to the search. If permission was given, resident rooms, belongings and pockets would be searched. If a resident did not allow search, then it would not be performed. In both cases, residents would be re-educated on the facility smoking policy which they were required to sign and reminded that noncompliance could result in facility discontinuing their smoking privileges and issuing a 30-day discharge notice. At 9:18 PM the DON provided a copy of the facility supervised smoking schedule, a document titled updated smoking list dated [DATE], and the results of the resident searches: Resident #4 wasn't happy but gave up her lighter; Resident #6 voluntarily gave up his lighter and then became upset; Resident #5 gave up her lighter; last search Resident #5 7:50 PM and no lighter found; Resident #7 last search 8:05 PM and was found to have 1 lighter; Resident #9 last search 7:44 PM and no lighter found; Resident #10 gave up his lighter; Resident #7 last search at 7:50 PM and was found to have a lighter. Review of the facility supervised smoking schedule revised 08/27/2019 revealed that following scheduled smoking times: 5:30AM-6:00AM; 7:15AM-7:45AM; 9:30AM-10:00AM; 11:00AM-11:30AM; 1:30PM-2:00PM; 3:30PM-4:00PM; 6:30PM-7:00PM; 8:30PM-9:00PM; 10:30PM-11:00PM. Review of the document titled updated smoking list dated 03/06/2020 revealed that Resident #4, Resident #5, and Resident #7 required smoking aprons. Medical record reviews were conducted: Resident #6 was initially admitted to the facility on [DATE], [DIAGNOSES REDACTED]. Resident #5 was initially admitted to the facility on [DATE], the smoking evaluation dated 10/08/2019 revealed that she required constant supervision while smoking, the resident had signed the facility smoking agreement/notice of policy on 03/04/2020, and her care plan included The resident will not smoke without supervision .The resident requires a smoking apron while smoking .The resident's smoking supplies are stored behind nursing station. Resident #9 was initially admitted to the facility on [DATE], the smoking evaluation provided by the facility dated 08/07/2019 was blank, the resident had

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

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) signed the facility smoking agreement/notice of policy on 3/04/2020, and his care plan revealed, The resident will not smoke without supervision .The resident's smoking supplies are stored behind nursing station. Resident #4 was initially admitted to the facility on [DATE], the smoking evaluation dated 0[DATE]20 revealed that the resident was a safe smoker and did not require supervision, the resident had signed the facility smoking agreement/notice of policy on 03/05/2020, her care plan was requested but not provided. Resident #8 was initially admitted to the facility on [DATE], [DIAGNOSES REDACTED].Notify charge nurse immediately if it is suspected resident has violated facility smoking policy .The resident's smoking supplies are stored behind nursing station. Resident #7 was initially admitted to the facility on [DATE], the smoking evaluation dated 02/12/202 revealed that the resident was a safe smoker and did not require supervision with smoking, he had signed the facility smoking agreement/notice of policy on 03/04/2020, there was nothing in his care plan about smoking. Resident #10 was initially admitted to the facility on [DATE], the smoking evaluation dated 0[DATE]20 revealed that the resident was a safe smokier and did not require supervision, he had signed the facility smoking agreement/notice of policy on 03/04/2020, his care plan revealed, The resident will not smoke without supervision .Notify charge nurse immediately if it is suspected resident has violated facility smoking policy .The resident's smoking supplies are stored behind the nurses station; locked box. The facility policy titled Smoking - Supervised effective date 11/30/2014, revision date 02/07/2020 revealed the following: The Center will provide a safe, designated smoking area for residents. For the safety of all residents the designated smoking area will be monitored by a staff member during authorized smoking times. Smoking is only allowed in designated areas and during designated times .The Center will retain and store matches, lighters, etc. for all residents .All residents who wish to smoke will sign an agreement attesting to abide by the smoking policies and procedures. The facility policy titled Resident Incident/Accident Reports effective date 11/30/2014, revision date 08/24/2017 revealed, Any happening not consistent with routine operations of the facility or care of a resident may warrant the completion of an incident report.
F 0926 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have policies on smoking.** Based on observation, interview, and policy review the facility failed to implement their policy related to safe supervised smoking for seven (Residents #4, 5, 6, 7, 8, 9, and 10) out of seven sampled residents. Findings Included: The facility policy titled Smoking-Supervised effective date 11/30/204, revision date 02/07/2020 revealed the following: The Center will provide a safe, designated smoking are for residents. For the safety of all residents the designated smoking area will be monitored by a staff member during authorized smoking times. Smoking is only allowed in designated areas and during designated times .The Center will establish and post designated smoking areas and times .The Center will retain and store matches, lighters, etc. for all residents. The posted document titled, Smoking Hours with revision dated 08/27/2019 revealed the following: Staff must be present .lunch time - no smoking .dinner time - no smoking .Please be advised that if we run a few minutes late we will adjust the smoking time as needed. The schedule was as follows: 5:30AM-6:00AM; 7:15AM-7:45AM; 9:30AM-10:00AM; 11:00AM-11:30AM; 1:30PM-2:00PM; 3:30PM-4:00PM; 6:30PM-7:00PM; 8:30PM-9:00PM; 10:30PM-11:00PM. Multiple observations were made of residents smoking in undesignated smoking areas, not during scheduled smoking times, and without supervision: 5:45 PM Resident #4 observed smoking on ramp directly outside of therapy gym exit where no smoking signs were posted; 6:16 PM Resident #5 was observed smoking in the patio area outside of the therapy gym exit; 7:40 PM Resident #5 and Resident #7 were observed smoking in the patio area outside of the therapy gym exit; 8:09 PM Resident #4 was observed smoking on the ramp directly outside of the therapy gym exit where no smoking signs were posted. Resident #10 was observed with a lighter at 7:51 PM on 03/09/2020 and Resident #8 was observed with a lighter at 8:09 PM on 03/09/2020. The following residents were confirmed by the facility Director of Nursing (DON) to have been found with lighters via person and room searches that took place between the hours of 5:45PM and 8:05 PM on 03/09/2020: Resident #4, Resident #5, Resident #6, Resident #7, Resident #8, Resident #9, and Resident #10. During interviews on 03/09/2020, the facility Nursing Home Administrator (NHA) and facility DON confirmed that per facility policy all resident smoking at the facility was to occur only at scheduled supervised smoking times and only in the designated smoking area. The NHA and DON confirmed that per facility policy all lighting materials including lighters were held by the facility.