STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676017	A. BUILDING _____ B. WING _____	**04/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RANGER CARE CENTER	**460 W MAIN ST RANGER, TX 76470**

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 -** Immediate jeopardy **Residents Affected -** Few	**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 interview and record review the facility failed to ensure adequate supervision to prevent accidents for 3 of 5 (Resident #s 1, 2 and 3) residents reviewed for smoking. a. On 04/05/20 at approximately 5:30 PM Resident #1 was severely burned while lighting a cigarette unsupervised. Staff reported he was at a hospital in another city on a ventilator [MEDICAL CONDITION] 45% of his body. b. There was not a system in place to communicate to staff which residents smoked, and which residents required supervision while smoking. c. Residents #2 and #3 said they had kept lighters in their possession (Note: The facility policy stated all lighters were to be kept at the nurse's station) prior to 04/05/20. d. Residents #1 and #3 did not have smoking safety assessments. An Immediate Jeopardy (IJ) was identified on 04/09/20. While the IJ was removed on 0[DATE]0/20, the facility remained out of compliance at a severity level of actual harm that was not immediate jeopardy and a scope of isolated because the facility was still monitoring the effectiveness of the Plan of Removal. These failures could result in resident injury or death. The findings included: Review of Resident #1's Admission Record dated 04/06/20 revealed he was originally admitted to the facility on [DATE] and readmitted on [DATE]. He was [AGE] years of age. His [DIAGNOSES REDACTED]. Review of Resident #1's Admission MDS dated [DATE] revealed he was documented as a tobacco user. Review of a Behavior Note dated 11/9/2019 revealed Resident #1 was observed picking up cigarette butts out of the public ashtrays outside. His wife was called and said she could not afford to buy him cigarettes. Review of Resident #1's computerized record revealed he was discharged from his 10/22/19 admission on 11/22/19. Review of the Nursing Admission Screening/History for his latest admitted d 03/12/20 noted he was a current smoker and dipped snuff. Review of Resident #1's Admission MDS dated [DATE] revealed he was not documented as a tobacco user. His BIMs was 14 indicating intact mental status. Review of Resident #1's Care Plan dated 03/12/20 revealed it did not address the use of tobacco. Review of Resident #1's electronic health record revealed no smoking safety assessment prior to his accident (04/05/20); however, there was an assessment dated [DATE] completed by the DON. The assessment documented that Resident #1 was safe to smoke with supervision. In an interview with the DON on 04/09/20 at 11:50 AM, that she knew Resident #1 was dipping snuff, but did not know he had been smoking. However, she said that cigarette butts had been found in his room. She said they had two residents that could pick up their lighter from the nurse and go smoke unsupervised. She confirmed a smoking safety assessment had not been done for Resident #1 prior to his accident. She stated she should have not completed a smoking safety assessment on Resident #1 after the accident, but she had been trying to cover all the bases. Review of a facility Provider Investigation Report dated 04/07/20 revealed that on 04/05/20 at 5:30 PM, Resident #1 was found in the central courtyard/smoking area on fire. Review of an Incident Note dated 04/05/20 at 6:34 PM revealed that a CNA had notified LVN A that a resident had caught himself on fire and had been put out with a fire extinguisher. LVN A assessed Resident #1 outside on the interior courtyard/smoking area patio and [MEDICAL CONDITION] the resident's upper arms, legs (including the residents left above the knee amputation stump), buttocks, upper and lower back, chest, and the neck with singed hair on the resident's head and face. Resident #1's was alert and oriented. Resident #1 told the nurse that it was windy outside, so he put his head and a lighter inside his shirt to light a cigarette and that his shirt caught on fire and he started to yell for help. In an interview with Resident #2 on 04/09/20 at 2:20 PM, she said she had been out on the patio with Resident #1, he had already been out there, sitting at the picnic table, when she went out to smoke. She did not see Resident #1 smoking at that time. She lit her cigarette and Resident #1 started banging on the window and the door. The cook came out of the kitchen and that was when she noticed that Resident #1 had a bunch of fire that just blew up all over him. In an interview with Cook A on 04/09/20 at 1:45 PM, he said that he had gone out with the residents who smoke in the past. He said residents didn't have lighters and he would have to light the cigarettes for them. He said that Resident #1 had been out in the designated smoking area every time Resident #1 had a chance and had seen Resident #1 smoking once or twice this visit. He said on the day of the accident (04/05/20) he had seen him going through the ashtrays. He said he had seen him do the same thing during his previous stay. Cook A said that at the time of the accident, he heard pounding on the window and door and when he looked he saw Resident #1 outside on the patio on fire. He rushed out and started putting out the flames with his shirt and then a CNA came with a fire extinguisher and they were able to get the flames out. In an interview with LVN A on 04/09/20 at 1:55 PM she said that on 04/05/20 just after evening meal time, she was in a resident room when she heard staff yelling emergency. She had staff call emergency services and went out to the patio, where she found the resident on the ground [MEDICAL CONDITION] most of his body. Resident #1 said he had put his head and a lighter under his shirt to light a cigarette because it was windy. She began to assess the resident, when the ambulance arrived. In an interview with the DON on 04/09/20 at 11:38 AM, that Resident #1's wife had notified them that the resident was at a hospital in another city in a medically induced coma [MEDICAL CONDITION] 45% of his body. In an interview with the Administrator on 0[DATE]0/20 at 10:50 AM she said Resident #1's wife had said he was at a hospital in another city on a ventilator, in medically induced coma, with 45% body of his body burned. He would need several surgeries, but that they were not confident he would survive surgery. In an interview with CNA A on 04/09/20 at 10:47 AM, he said that he had seen Resident #1 outside smoking for a couple of days prior to the resident's accident. He said he thought the resident could have his own lighter. CNA A said that they were usually just told which residents needed to be supervised while smoking. He said residents were not supposed to have a lighter; but could get one from the nurse and light their own cigarettes. In an interview with CNA B on 04/09/20 at 11:03 AM, she said that Resident #1 dipped snuff and smoked sometimes, but that she had not seen him out smoking during this admission. She said residents were supposed to get the lighter from the nurse. In an interview with CNA C on 04/09/20 at 11:12 AM, she said that staff were verbally told when a resident was admitted if they needed to be supervised while smoking. She said that they were verbally told which residents needed to be supervised to smoke. She said residents could keep their cigarettes but were not supposed to have a lighter. In an interview with LVN B on 04/09/20 at 11:20 AM, he said that he was aware that Resident #1 had a history of [REDACTED]. He did not think he had been smoking this visit. In an interview with LVN C on 04/09/20 at 11:28 AM, she said that she had seen Resident #1 out smoking for a couple of days prior to his accident. She said residents were supposed to be assessed for smoking safety on admission, and if they were assessed as being safe could smoke unsupervised. In an interview with the Administrator on 04/09/20 at 12:00 Noon, she said that residents were assessed for smoking safety on admission, quarterly and as needed. She said that staff would light resident's cigarettes but would not stay outside monitoring the residents if they had been assessed as being able to smoke safely without supervision. She said they had not had any residents who could not smoke without supervision in a long while. The Administrator also said that it was her expectation that staff would have completed a smoking safety assessment on Resident #1 to see if he could smoke without being supervised. She said that if staff had seen him outside smoking she would expect the staff to say something to their supervisor, so action could be taken. In an interview with LVN D on

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) 04/09/20 at 1:36 PM she said that they only had four residents who smoked and that staff just know who can smoke by themselves. She said that she had seen Resident #1 after the fire was out and that he said he had lit a cigarette under his shirt. In an interview with LVN A on 04/09/20 at 1:55 PM, she said she was not aware that Resident #1 smoked but knew that he had been dipping snuff. Resident #2 Review of Resident #2 computerized medical record revealed she was admitted to the facility on [DATE]. She was [AGE] years of age. Her [DIAGNOSES REDACTED]. Review of Resident #2 Annual MDS dated [DATE] revealed she used tobacco and had a BIMS of 15 indicating intact mental status. Review of Resident #2 Smoking Safety screenings dated 08/09/19, 11/07/19, and 01/30/20 indicated she was safe to smoke without supervision and was able to use her own lighter to light cigarettes. (Note: facility policy stated residents were to get lighters from the nurse's station.) In an interview with Resident #2 on 04/09/20 at 2:20 PM, she said that prior to the accident, she had kept her lighter in the side pocket of her purse with her cigarettes. Resident #3 Review of Resident #3's computerized medical record revealed he was admitted to the facility on [DATE]. He was [AGE] years of age. His [DIAGNOSES REDACTED]. Review of Resident #3's Admission MDS dated [DATE] indicated he was a current tobacco user. Review of Resident #3's Care Plan last updated 01/27/20 revealed a problem initiated 10/17/19 He is a smoker. Review of Resident #3's computerized assessments revealed no Smoking-Safety Screens from admission on 10/1[DATE]9 until 04/08/20. In an interview with the DON on 04/09/20 at 5:05 PM she confirmed that there was not a smoking assessment prior to 04/08/20 for Resident #3. In an interview with Resident #3 on 04/09/20 at 2:15 PM, he said that before the accident he could keep his lighter with him. He said that Resident #1 had been out smoking several times. In an interview with the Administrator on 0[DATE]0/20 at 10:50 AM, said she felt the failure that caused this accident was a communication failure with the staff and that the DON should have known the resident had been smoking. She said staff should have reported seeing the resident smoke to the DON. In an interview with the ADON on 0[DATE]0/20 at 11:33 AM she said that it had become normal for staff to expect Resident #1 to be non-compliant. She said that she had found cigarette butts in his room during this stay and had spoken with Resident #1 and thought it was taken care of. She felt there was a failure of communication between the shifts. In an interview with the DON on 0[DATE]0/20 at 11:58 AM, she said she knew Resident #1 was non-compliant, she had believed him when he said he was not smoking, but, that in hindsight, it was her responsibility to assess all the residents. Review of the facility Smoking Policy dated 02/29/15 revealed the following: It is the policy of (facility name) to ensure the safety of all the residents. Residents, visitors, and employees may only smoke in the designated smoking area, which is the courtyard located in the center of the facility. Resident's will be assessed every six months and as needed to determine the need for supervision to smoke. All resident's that are able to smoke without supervision are allowed to keep their cigarettes. All resident lighters are to be kept at the nurse's station. A metal container with a self-closing lid to empty/dump ashes will be provided at all times in designated smoking area(s). Noncombustible ashtrays will be provided for residents, visitors, and employees to use in areas where smoking is permitted. Absolutely no smoking is allowed in any rooms, wards, or compartment where flammable liquids, combustible gases, or [MED]gen or inhalation therapy equipment is used or stored. The safety of our residents is of the utmost importance. We ask your consideration in abiding by this policy. The Administrator, Director of Nurses (DON) were informed of the identification of an immediate jeopardy situation on 04/09/20 at 5:05 p.m. The Administrator was provided the IJ template. Review of the facility's Plan of Removal dated 04/09/20 documented: The smoking/tobacco assessment has been revised so that every resident who is admitted into the facility will have a smoking/tobacco assessment completed. This assessment will be done on admission, quarterly and as needed. This assessment has been added to the new admission check list to ensure compliance. When unknown tobacco user is discovered smoking or digging through ashtrays, staff will either stay with resident to ensure safety while they are smoking or remove the resident from the smoking area. Staff will confiscate tobacco paraphernalia and give to supervisor. Once inside the facility the staff member will immediately report it to the supervisor. The supervisor will report to the Director of Nursing. The DON will assess resident for tobacco usage. Resident will be educated on facility smoking policy and if lighter is found, it will be taken to the charge nurse per policy. DON will update care plan to reflect tobacco usage. Incident will be documented in residents chart. Smoking information sticker will be added to residents information located on their door name plate. This change will be added to the nursing 24 hour report and will be reported on all shift reports. Ashtrays will be emptied after every use in the red fire proof receptacle. Staff will be in-serviced of this new policy as they pick up their paycheck 0[DATE]. Any staff that are not available on 0[DATE]0/20 will be trained/in-serviced prior to beginning work on their next shift. The smoking/tobacco policy has been revised to include all smoking residents will be supervised while smoking. Staff will be in-serviced and trained as they pick up their paycheck on 0[DATE]0/20. Any staff member that is not available on 0[DATE]0/20 will be trained/in-serviced prior to working their next shift. The facility utilizes a sticker system on the residents name plate as a way of communication. A smoking sticker (bear) has been added to all smokers. All staff have been given access to the residents Care Profile, which includes such information as Smoking Status. Staff will be in-serviced and trained as they pick up their paycheck on 0[DATE]. Any staff member that is not available on 0[DATE]0/20 will be trained/in-serviced prior to working their next shift. Smoking aprons have been ordered and will be utilized per assessment. We have included a smoking/tobacco statement in the New Admission packet. This includes our policy as well as informing family not to bring lighters to the resident or in the facility. Responsible party will be notified and notification will be documented. The smoking/tobacco policy has been added to the new hire packet. Employee will sign that they understand and it will stay in employee file. All residents in the facility have a current smoking assessment completed and a revised care plan to include supervised smoking. All residents who are able will sign the new policy stating that they have been informed of the revisions. The following residents are our current smokers: (Resident Id #s 2, 3, 4 and 5) These residents have a new smoking assessment, a revised care plan to include smoking supervision and have been informed of our new policy. The surveyor verified the completion of the Plan of Removal as follows: In-services were conducted on 04/09/20 and 0[DATE]0/20 by the Administrator and Business Office Manager regarding the new smoking policy, procedures and rules regarding smoking and having a lighter in the facility and the new sticker identification system. Interviews with staff on the day and evening shift: 2 nurses, 3 aides, and 2 other personnel revealed the staff understood the content and answered questions appropriately. Interviews with Residents 2, 3 and 5 revealed they had been instructed on the new smoking policy. They were not to go smoke without staff and they were no longer to keep their lighters. Resident #4 refused to be interviewed. Residents were observed on 04/09/20 and 0[DATE]0/20 with staff while smoking in the designated smoking area. The new smoking assessment was reviewed and all current residents were assessed. Resident #s 2,3, 4 and 5's records were reviewed for current smoking safety assessments and their care plans were updated. Bear stickers were noted on the resident door for those who smoke. Smoking Apron order receipt was reviewed. Interview on 0[DATE]0/20 at 3:25 PM the Administrator and DON were informed the IJ was lifted but the facility remained out of compliance at a severity level of actual harm that was not immediate jeopardy and a scope of isolated because the facility was still monitoring the effectiveness of the Plan of Removal.