STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155426	A. BUILDING _____ B. WING _____	05/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIGNATURE HEALTHCARE OF TERRE HAUTE	3500 MAPLE AVE TERRE HAUTE, IN 47804

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 observation, record review, and interview, the facility failed to ensure smoking materials were secured and adequate monitoring and supervision were provided for 3 of 9 residents (Residents B, C, and D) reviewed for safe smoking. This resulted in Resident B smoking in bed with oxygen in place, igniting a fire to Resident B's face and bed and causing a second degree burn (a partial thickness burn that affects the lower layer of the skin and can cause pain, redness, and swelling) to the nose and additional unspecified degree [MEDICAL CONDITION] the head, face, and neck. The Immediate Jeopardy began on 5/18/20, when Resident B attempted to smoke a cigarette in her room. This ignited the resident's oxygen resulting in a fire to the resident's face and bed. Resident B sustained second [MEDICAL CONDITION] her nose and an unspecified degree of burn to the head, face, and neck. Resident B was sent to the local hospital and then transferred by critical care ambulance to a burn unit at a specialty hospital. The Administrator, Director of Nursing, and Corporate Nurse Consultant were notified of the Immediate Jeopardy at 5:14 p.m. on 5/19/20. The immediate jeopardy was removed on 5/19/20, but noncompliance remained at a lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: 1. Resident B's record was reviewed on 5/19/20 at 12:03 p.m. [DIAGNOSES REDACTED]. A quarterly Minimum Data Set (MDS) assessment, dated 3/24/20, indicated the resident was cognitively intact and received oxygen therapy. A current face sheet, as of 5/19/20, indicated the resident was a current, every day smoker. A smoking assessment, dated 6/12/19, indicated the resident was able to smoke safely and did not require supervision. Smoking materials were to be kept at the nurses' station or a designated location, and oxygen was to be removed prior to smoking. A physician's orders [REDACTED]. A document titled, SMOKING, was signed by the resident and facility staff on 6/12/19. The document indicated smoking was prohibited inside the facility and on the property, all smoking materials were to be kept secured by facility staff and were not to be kept in the resident's possession, a care plan would be developed to include smoking materials to be secured in a locked box and immediately secured upon the resident's return to the facility from smoking, violation of the policy should be reported immediately to the Administrator and would result in discharge from the facility. A care plan, dated 6/13/19, and last revised 5/19/20, indicated the resident was a smoker and was at risk for safety concerns related to desire to smoke and was designated as a safe smoker. Interventions, dated 6/13/19, included, but were not limited to, resident observed every shift for safety, obtain physician's orders [REDACTED]. to the facility staff following smoke breaks. A physician's orders [REDACTED]. Smoking assessments, dated 11/20/19, 1/13/20, 1/22/20, and 2/22/20, indicated the resident was able to smoke safely and did not require supervision. Smoking materials were to be kept at the nurses' station or a designated location, and oxygen was to be removed prior to smoking. A nursing note, dated 5/18/20, indicated at approximately 5:00 a.m., the fire alarm sounded and the resident cried out for help. The resident was found sitting on the floor in the doorway of her room, with noticeable smoke coming from the room. The resident had blackened areas on her face around her lips and up to her nose. The resident admitted she had been smoking and reported difficulty breathing. The resident was removed from the area, and another staff member retrieved a fire extinguisher and put out the fire in the resident's room. The fire department and emergency medical services (EMS) arrived within minutes, and the resident was immediately transported to the hospital. All other residents were evacuated from the hallway to the dining room. The resident was last seen prior to the incident by a Certified Nursing Assistant (CNA) at 4:35 a.m., with nothing unusual noted. During the investigation, smoking materials were found in the resident's room. The fire was observed to be contained to the resident's bed. An emergency room (ER) report, dated 5/18/20, indicated the resident had an endotracheal (ET) tube (a breathing tube inserted through the windpipe to deliver oxygen to the lungs) placed. The assessment indicated the resident had second [MEDICAL CONDITION] the nose and an unspecified degree of [MEDICAL CONDITION] the head, eyes, ears, nose, and throat. There was soot present on both cheeks and nasal hair singeing. A preliminary report from the ER, dated 5/18/20, indicated the resident needed to be transferred to a burn center. The resident was transferred by critical care ambulance to another hospital. On 5/19/20 at 10:57 a.m., Resident B's room, prior to her hospital admission, was observed. The room was in the process of being repaired. A magnet on the door frame indicated no smoking related to oxygen in use. During an interview, on 5/19/20 at 3:30 p.m., Resident B was observed back from the hospital and lying in bed, with red scabbed areas around her nose and mouth. At the same time, Resident B indicated the night before the fire, she went out to smoke with her roommate and had not turned her smoking materials back in. She kept the cigarettes and lighter in her pocket. No staff was at the front desk, and no staff members asked her for her smoking materials. Sometime through the night, she woke up and lit a cigarette, which started a fire. She rolled out of bed, into the hallway, and yelled for help. Resident B indicated she had pain at a nine on a pain scale of one to ten. 2. Resident C's record was reviewed on 5/19/20 at 12:34 p.m. [DIAGNOSES REDACTED]. to think, feel, and behave clearly) unspecified, and nicotine dependence unspecified uncomplicated. An annual Minimum Data Set (MDS) assessment, dated 5/1/20, indicated the resident was cognitively intact. A smoking assessment, dated 5/15/19, indicated the resident was able to smoke safely and did not require supervision. Smoking materials were to be kept at the nurses' station or a designated location. A care plan, dated 5/15/19, and last reviewed on 5/18/20, indicated the resident smoked and was at risk for safety concerns related to the desire to smoke and was designated as a safe smoker. Interventions included, but were not limited to, obtain a physician's orders [REDACTED]. A document titled, SMOKING, was signed by the resident and facility staff on 5/16/19. The document indicated smoking was prohibited inside the facility and on the property, all smoking materials were to be kept secured by facility staff and were not to be kept in the resident's possession, a care plan would be developed to include smoking materials to be secured in a locked box and immediately secured upon the resident's return to the facility from smoking, violation of the policy should be reported immediately to the Administrator and would result in discharge from the facility. Smoking assessments, dated 7/20/19, 11/06/19, and 1/20/20, indicated the resident was able to smoke safely and did not require supervision. Smoking materials were to be kept at the nurses' station or a designated location. A physician's orders [REDACTED]. Smoking assessments, dated 2/20/20, 5/01/20, and 5/18/20, indicated the resident was able to smoke safely and did not require supervision. Smoking materials were to be kept at the nurses' station or a designated location. A document titled, SMOKING, was signed by the resident and facility staff on 5/18/20. The document indicated smoking was prohibited inside the facility and on the property, all smoking materials were to be kept secured by facility staff and were not to be kept in the resident's possession, a care plan would be developed to include smoking materials to be secured in a locked box and immediately secured upon the resident's return to the facility from smoking, violation of the policy should be reported immediately to the Administrator and would result in discharge from the facility. On 5/19/20 at 2:43 p.m., Resident C was observed to sign out on the LOA log, retrieve her smoking materials, and go out to smoke independently. During an interview, on 5/19/20 at 11:08 a.m., Resident C indicated Resident B was her

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) roommate. Resident C was out of the room when the fire occurred. She has smoked since she admitted to the facility. They used to be able to keep their smoking materials, cigarettes and lighters, with them in their rooms, but now they have to turn everything into the front desk. This all changed yesterday after the fire. Until yesterday, she was not aware she should not have kept her cigarettes and lighter with her. No staff had ever said anything to her about it. During an interview, on 5/19/20 at 11:53 a.m., Resident C indicated the night before the fire, she and Resident B went out to smoke. They kept their smoking materials, as usual, and returned to their room. She had never kept her smoking materials locked up prior to this incident, and had not been offered a place to lock them up. 3. Resident D's record was reviewed on 5/19/20 at 4:28 p.m. [DIAGNOSES REDACTED]. An admission Minimum Data Set (MDS) assessment, dated 3/16/20, indicated the resident was cognitively intact and received oxygen therapy. A physician's orders [REDACTED]. An undated physician's orders [REDACTED]. A care plan, dated 2/28/20, and last reviewed on 5/18/20, indicated the resident smoked and was at risk for safety concerns related to the desire to smoke, and the resident was designated as an impaired smoker related to the failure to smoke in designated areas. Interventions included, but were not limited to, obtain physician's orders [REDACTED]. A document titled, SMOKING, was signed by the resident and facility staff on 3/26/20. The document indicated smoking was prohibited inside the facility and on the property, all smoking materials were to be kept secured by facility staff and were not to be kept in the resident's possession, a care plan would be developed to include smoking materials to be secured in a locked box and immediately secured upon the resident's return to the facility from smoking, violation of the policy should be reported immediately to the Administrator and would result in discharge from the facility. A smoking assessment, dated 3/26/20, indicated the resident was able to smoke safely and did not require supervision. Smoking materials were to be kept at the nurses' station or a designated location. A smoking assessment, dated 5/18/20, indicated the resident was able to smoke safely and did not require supervision. Smoking materials were to be kept at the nurses' station or a designated location. During an interview, on 5/19/20, at 2:37 p.m., Resident D indicated he had smoked since he was admitted to the facility. He smoked independently. There had been a fire a day ago because another resident smoked in her room, and after that a new policy was started where the residents were not allowed to keep their smoking materials in their rooms. Prior to the incident, he kept one pack of cigarettes and a lighter in his room with him. He kept any extra cigarette packs at the front desk. He had lived at the facility for about three months, and when he was admitted he was told it was fine to keep his smoking materials in his room. He was never offered a lockbox or anywhere secure to keep the smoking materials in his room. He kept them in the drawer of his dresser. During an interview, on 5/19/20 at 10:59 a.m., Licensed Practical Nurse (LPN) 5 indicated she was working the hall Resident B was on prior to her hospital admission. She was not sure which residents on the hall smoked, because she had not worked the hall very many times. Smoking materials were supposed to be kept at the front desk with the receptionist during the day and at the south nurses' station at night. She was not sure if that was a new policy. She was not sure what happened during the fire incident. During an interview, on 5/19/20 at 11:21 a.m., Hospitality Aide 6 indicated she was familiar with Residents B and C. Prior to yesterday, Resident C always had her lighter and cigarettes with her and had not turned them into the front desk. The residents were supposed to give smoking materials to the receptionist during the day and the south unit nurse at night after they were done smoking, but this was not always done. She was not sure if this was a new policy. Some residents had kept smoking materials with them since she started working at the facility about a month ago. She was not aware Resident B smoked. During an interview, on 5/19/20 at 11:25 a.m., Certified Nursing Assistant (CNA) 7 indicated she had worked at the facility for about a week and a half. She was aware Residents B and C smoked and normally kept their smoking materials in their room, and was told during her training this was acceptable. During an interview, on 5/19/20 at 12:45 p.m., Receptionist 4 indicated all residents were supposed to turn in their smoking materials to her after they were done smoking during the day and to the south unit nurse at night; however, they had not always done this. Residents B and C often kept their smoking materials with them. When residents kept their smoking materials, she was supposed to report it to the Administrator. As of 5/18/20, residents turned in their smoking materials after they were done smoking. During an interview, on 5/19/20, at 2:45 p.m., a tackle box was observed to contain resident smoking supplies at the front desk. At the same time, Receptionist 9 indicated all smoking materials were kept in the tackle box. When the receptionist went home, the tackle box was taken to the south unit. During an interview, on 5/19/20 at 3:05 p.m., the Administrator indicated she received a call from the facility between 5:10 a.m., and 5:15 a.m., on 5/18/20, and was notified there had been a fire. She instructed staff to evacuate the residents on the unit to the dining room. Fire alarms sounded at 5:09 a.m., and the fire department arrived at the facility at 5:14 a.m. Staff extinguished the fire to Resident B's bed with a fire extinguisher. Resident B returned to the facility today. Resident B lit a cigarette during the night on 5/18/20, which ignited her oxygen, causing a fire. The resident made it out to the hallway and was provided assistance. The resident had not smoked in the building prior to this incident. All smokers were required to sign an agreement that smoking materials would be turned in after they smoked. The staff were doing weekly room sweeps to ensure smoking materials are not in the residents' rooms. This was being done occasionally prior to the incident, but not weekly. She was not aware Residents B, C, and D had not typically turned in their smoking materials prior to the incident. This should have been reported to her by the receptionist. Since the incident, the receptionist was to stop residents and request their smoking materials back after they were done smoking. This had not happened consistently before 5/18/20. Regardless of whether or not residents were assessed as safe smokers, they were not to keep smoking materials in their rooms. At the same time, the Director of Nursing (DON) indicated there were currently eight residents who smoked independently, not including Resident B. Resident B planned to not smoke anymore since her return to the facility. On 5/19/20 at 2:55 p.m., the DON provided a document titled, SMOKING, and indicated it was the policy currently being used by the facility. The policy indicated, Provided to Residents and Families Upon Admission .Smoking is prohibited inside the Nursing Facility and on .property. A licensed nurse will complete a Safe Smoking Evaluation at the time of admission, quarterly thereafter and with any change of condition, a licensed nurse will contact your primary care physician upon admission/readmission to request an order for [REDACTED].are to be secured by facility staff. Smoking materials are prohibited to be kept in the Resident's possession. A licensed nurse will develop a Care Plan with Interventions which will include keeping all smoking materials secured in a locked box. Your Smoking materials will be available to you when you go LOA. Materials must be secured immediately upon your return to the facility. Violation of this Smoking Notice will be reported immediately to the Administrator. The violation will result in discharge from the facility. The Immediate Jeopardy that began on 5/18/20 was removed on 5/19/20 when the facility completed staff education on the facility smoking policies and practices, identifying all resident smokers, checking BIMS levels, and conducting reassessments using the Safe Smoking Assessment, updating the care plans, conducting room sweeps for smoking materials, and re-educating smoking residents on the smoking policy and storage of smoking materials. The Immediate Jeopardy was removed on 5/19/20, but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy, because of the need to further monitor staff and residents for compliance to the smoking policies and procedures This Federal tag relates to Complaint IN 995. 3.1-45(a)(1) 3.1-45(a)(2)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure personal protective equipment (PPE) was kept readily available for staff prior to entering residents' rooms when isolation precautions (specialized precautions to prevent the spread of germs) were in place for 9 of 9 residents reviewed for infection control (Residents E, F, G, H, J, M, K, B, and L). Findings include: 1. On 5/20/20 at 3:48 p.m., Resident E's room was observed with a sign on the door to see the nurse prior to entering. A three drawer cart with personal protective equipment (PPE) was observed directly inside the resident's room, next to the door. Resident E's record was reviewed on 5/20/20 at 4:34 p.m. A physician's orders [REDACTED].). 2. On 5/20/20 at 3:49 p.m., Resident F's room was observed with a sign on the door to see the nurse prior to entering. A three drawer cart with PPE was observed directly inside the resident's room, next to the door. Resident F's record was reviewed on 5/20/20 at 4:43 PM. A physician's orders [REDACTED]. 3. On 5/20/20 at 3:50 p.m., Resident G's room was observed with a sign on the door to see the nurse prior to entering. A three drawer cart with PPE was observed approximately five feet inside the resident's room. Resident G's record was reviewed on 5/20/20 at 4:44 p.m. A physician's orders [REDACTED]. 4. On 5/20/20 at 3:51 p.m., Resident H's room was observed with a sign on the door to see the nurse prior to entering. A three drawer cart with PPE was observed directly inside the resident's room, next to the door. Resident H's record was reviewed on 5/20/20 at 4:49 p.m. A physician's orders [REDACTED]. 5. On 5/20/20 at 3:52 p.m., Resident J's room was observed with a sign on the door to see the nurse prior to entering. A three drawer cart with PPE was observed directly inside the resident's room, next to the door. Resident J's record was reviewed on 5/20/20 at 4:50 p.m.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) Census information indicated the resident admitted to the facility on [DATE]. A physician's orders [REDACTED]. 6. On 5/20/20 at 3:55 p.m., Resident M's room was observed with a sign on the door to see the nurse prior to entering. A three drawer cart with PPE was observed directly inside the resident's room, next to the door. Resident M's record was reviewed on 5/20/20 at 4:56 p.m. Census information indicated the resident admitted to the facility on [DATE]. A physician's orders [REDACTED]. 7. On 5/20/20 at 3:57 p.m., Resident K's room was observed with a sign on the door to see the nurse prior to entering. A three drawer cart with PPE was observed directly inside the resident's room, next to the door. Resident K's record was reviewed on 5/20/20 at 4:51 p.m. Census information indicated the resident readmitted to the facility, from the hospital, on 5/19/20. A physician's orders [REDACTED]. 8. On 5/20/20 at 3:58 p.m., Resident B's room was observed with a sign on the door to see the nurse prior to entering. A three drawer cart with PPE was observed directly inside the resident's room, next to the door. Resident B's record was reviewed on 5/19/20 at 12:03 p.m. Census information indicated the resident readmitted to the facility, from the hospital, on 5/19/20. A physician's orders [REDACTED]. 9. On 5/20/20 at 3:59 p.m., Resident L's room was observed with a sign on the door to see the nurse prior to entering. A three drawer cart with PPE was observed directly inside the resident's room, next to the door. Resident L's record was reviewed on 5/20/20 at 4:54 p.m. Census information indicated the resident admitted to the facility on [DATE]. A physician's orders [REDACTED]. During an interview, on 5/20/20 at 3:55 p.m., Certified Nursing Assistant (CNA) 10 indicated if a resident required isolation precautions, she checked with the nurse to find out what PPE was required prior to providing care. The carts with the PPE were kept inside the residents' rooms. When she needed to provide care, she entered the room, donned appropriate PPE, and provided care. She had wondered if the PPE should have been outside of the room, so she would not have had to enter the room prior to donning her PPE. During an interview, on 5/20/20, at 4:01 p.m., the Director of Nursing (DON) indicated PPE was kept inside the residents' rooms. They had discussed the possibility of moving it outside the room, but they had not changed the procedure. On 5/20/20 at 1:59 p.m., the DON provided a document titled, Isolation-Categories of Transmission-Based Precautions, and indicated it was the policy currently being used by the facility. The policy indicated, Policy Statement: Transmission-Based Precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents. Policy Interpretation and Implementation: .2. Transmission-based precautions are additional measures that protect staff, visitors, and other residents from becoming infected. These measures are determined by the specific pathogen and how it is spread from person to person. The three types of transmission-based precautions are contact, droplet, and airborne .Contact Precautions .4. Staff and visitors will wear gloves (clean, non-sterile) when entering the room .5. Staff and visitors will wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed .Droplet precautions: .3. Masks will be worn when entering the room. 4. Gloves, gown and goggles should be worn if there is risk of spraying respiratory secretions 3.1-18(b)(1)