STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365148	A. BUILDING _____ B. WING _____	**06/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAK PAVILION NURSING CENTER	**510 OAK STREET CINCINNATI, OH 45219**

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 -** 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 medical record review, observation, staff interview, resident interview, review of the facility investigation and policy review the facility failed to ensure a resident did not smoke while using oxygen and failed to ensure a resident was not in possession of smoking materials. This affected one Resident (#2) of three reviewed for smoking. The facility identified six residents who smoked and used oxygen. The facility census was 80. Findings include: Review of the medical record revealed Resident #2 had an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the smoking assessment dated [DATE] revealed he was alert and oriented and was able to safely smoke with minimal assistance. Review of the annual assessment dated [DATE] revealed the resident had intact cognition. The resident required supervision and setup help only for bed mobility, transfers, walking in his room and corridor and locomotion on the unit and he required one-person physical assistance for locomotion off the unit. Review of the plan of care revealed he had a potential for smoking safety issues related to not following facility policies. Interventions included education regarding the dangers of smoking with oxygen and designated smoking areas. Review of the nurse progress notes dated 06/09/20 revealed Resident #2 had been outside with his oxygen on and was smoking. The resident presented with reddened areas to his left cheek, left nostril and below the nares. Resident #2 had no complaint of pain; and his lung sounds were clear throughout. A topical antibiotic ointment was applied to the reddened areas on his cheek, nostril and nares and oxygen saturations readings were checked every shift. Review of the facility investigation dated 06/09/20 revealed Resident #2 had been out in the smoking area and obtained a new wound (burn) to his facial area. The report further detailed a nurse from the first floor stated she had seen the resident with difficulty catching his breath and noted an area of discoloration to his face. Resident #2 reported he had caught on fire. He was assessed by his nurse and had areas of burn noted to his left cheek, left side of his nose and directly below his nares. Further review of the facility investigation revealed Resident #2 was noted as not compliant with his safety intervention as he was smoking with oxygen turned on and the oxygen cannula in his nose. New interventions to prevent reoccurrence listed by the facility included to have smoking supervision and a smoking apron. Interview on 06/18/20 at 7:43 A.M., Licensed Practical Nurse (LPN) #20 stated she had worked the second floor when LPN #30 brought Resident #2 up from the first floor and had noticed areas on his face. LPN #30 gave report as it looked like the resident had burnt himself. LPN #20 stated Resident #2 had been outside smoking with oxygen on and it burnt him. LPN #20 stated they tried to educate residents on smoking and had warned him before. LPN #20 stated she had contacted the Nurse Practitioner (NP) and Resident #2 had a small area on his cheek, nose and nostrils. LPN #20 stated she applied topical antibiotic ointment on the areas as ordered by the NP and she assessed his nostrils by using a flashlight and assessed his lung sounds which were clear and he had no other respiratory issues. Interview on 06/18/20 at 8:05 A.M., LPN #30 stated she had just completed her medication pass when Resident #2 was coming in from smoking and she turned around and looked at him and she thought he had fallen. She asked Resident #2 what was wrong, and the resident stated he caught on fire and he had visible red marks. Resident #2 told her he had oxygen on, and the oxygen tubing was visibly burnt. She further stated Resident #2's face was red on the left side of his nose and on his left cheek. Interview and observation on 06/18/20 at 9:23 A.M., Resident #2 was sitting in his room and observed to have red areas to his left cheek and nose he stated at the time of the incident he was on the ramp smoking when his tubing caught fire, he pulled the oxygen tubing off and put the fire out. Resident #2 stated he forgot and didn't turn the oxygen off and admitted he had been told before not to smoke with oxygen. He stated no one was around him when the incident occurred and would not reveal how he obtained the smoking materials he had in his possession. Resident #2 further stated he was an unsupervised smoker before and now he had to be supervised. Interview on 06/18/20 at 10:40 A.M., the Administrator stated residents were not to have smoking materials in their possession and they should only smoke in the designated area. Follow up interview on 06/18/20 at 11:05 A.M., Resident #2 stated he had bought cigarettes from another resident and received a lighter from someone in the courtyard, however he continued to express he would not give any names who he bought these items from. Interview on 06/18/20 at 12:57 P.M., Aide #99 stated Resident #2 tried to sit on the ramp going out to the smoking area and had to often be reminded not to sit there. He stated the resident asked to be pushed back into the building and he had not noticed anything wrong with the resident. Aide #99 further stated he had not given the resident smoking materials and had not seen him smoking on the day of the incident. Review of facility policy titled Smoking Policy for Resident Signature dated 05/01/18 revealed the ramp leading to and from the courtyard was not to be used as an area to smoke. Residents are not to keep smoking materials in their rooms. These products must remain in the designated area. This deficiency substantiates Complaint Master Control Number OH 437, Complaint Number OH 8 and Complaint Number OH 416.

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.