STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075210	A. BUILDING _____ B. WING _____	**10/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WATERBURY GARDENS NURSING AND REHAB	**128 CEDAR AVENUE WATERBURY, CT 06705**

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** Based on clinical record review, observations, facility documentation review, facility policy review, and interviews for four residents (R #1, R #2, R #3, and R #4) reviewed for resident rights, the facility failed to ensure residents were permitted to exercise their rights to smoke if desired. The findings include: Observations on 10/3/2020 at 1:20 PM identified R #1, #2 and #3 in the parking lot who were smoking without the benefit of staff supervision. R #4 was observed to join the group of residents, was provided a cigarette by R #1, and R #4 was observed to smoke. Interview and observation with RN #1 and the residents on 10/3/2020 at 1:36 PM identified the facility was a non-smoking facility. R #1, R #2, R #3, and R #4 indicated that they had been offered nicotine patches, which they reported did not work for them and they preferred to smoke. Interview, clinical record review, and facility documentation review with the DON, RN #1 and RN #2 on 10/3/2020 at 2:45 PM identified the facility had been a smoking facility (allowed residents to smoke) prior to the COVID-19 pandemic. The DON indicated that many residents who were smokers were positive for COVID-19; the facility had suspended smoking at that time and was now a non-smoking facility. Interview identified that although the facility currently had no COVID-19 positive staff or residents, and the facility was aware that residents had refused nicotine patches and expressed a desire to smoke, the facility had not changed their practice to allow resident smoking. Review of facility Resident Rights, dated November 2016, directed in part that residents have the right to be fully informed, orally and in writing of changes in rights and the facility ' s rules. The policy further directed that residents have the right to choose activities consistent with their interests, and to make choices about aspects of their life that are significant to them.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, facility documentation review, facility policy review, and interviews for three sampled residents (R #1, R #2, and R #3) reviewed for accidents, the facility failed to ensure the care plan was updated to reflect current care. The findings include: Observations on 10/3/2020 at 1:20 PM identified R #1, #2, #3 and #4 in the parking lot who were smoking without the benefit of staff supervision. Interview and observation with RN #1 on 10/3/2020 at 1:36 PM and with R #1, R #2, R #3 and R #4 identified they had extinguished their cigarettes by the time RN #1 arrived. RN #1 indicated the facility was a non-smoking facility, residents should not be smoking. Interview with the DON, RN #1 and RN #2 on 10/3/2020 at 2:45 PM identified after a resident body search, R #2 was found to have an empty box of cigarettes and a lighter on his/her person, and the items were removed by staff. R #3 and R #4 were not found to have any smoking paraphernalia. R #1 left the facility for a medical appointment with the plan that R #1 would be searched upon return to the facility. Interview and observation with the DON on 10/4/2020 at 10:30 AM identified R #4 was searched upon return from his/her appointment and was found to have a full, unopened pack of cigarettes and a lighter, and the items were removed by staff. a. R # 1 ' s [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS) assessment dated [DATE] identified that R #1 was alert and oriented (BIMS score of fifteen out of fifteen), and was non-ambulatory. A smoking assessment dated [DATE] identified R #1 was a non-smoker. The Resident Care Plan (RCP) dated 6/18/2020 identified a fall risk with interventions to lock R #1 ' s wheelchair. Review of the clinical record identified the following: nurse ' s note dated 9/12/2020 at 2:36 PM identified R #1 was observed outside smoking and the supervisor was notified. A late entry nurse ' s note for 9/12/2020, dated 9/15/2020 at 4:51 PM identified R #1 was observed smoking in the parking lot, was verbally aggressive, and showed his/her pockets (contents). Nurse ' s note dated 9/18/2020 at 12:28 PM identified on 9/17/2020 staff observed resident smoking in front of the facility, R #1 refused to extinguish the cigarette. R #1 allowed a search of his/her bag and staff located two (2) packs of cigarettes and a lighter. Interview and clinical record review with the DON, RN #1 and RN #2 on 10/3/2020 at 2:45 PM identified RN #1 observed R #1 smoking in the parking lot on 10/2/2020 without staff supervision. Review of the RCP failed to identify a care plan to reflect his/her smoking status, and for non-compliance with smoking regulations. During an interview and review of the clinical record with the ADON on 10/4/2020 at 10:44 AM identified she was unable to provide documentation that R #1 ' s care plan was updated to reflect his/her smoking status and non-compliance with smoking regulations in the facility. She stated the care plan should have been updated. b. R #2 ' s [DIAGNOSES REDACTED]. The smoking assessment completed 2/4/2020 identified R #2 was a smoker and required supervision with smoking. The annual Minimum Data Set (MDS) assessment dated [DATE] identified that R #2 was alert and oriented (BIMS score of fourteen out of fifteen, indicative of no cognitive impairment) and required use of a wheelchair. The Resident Care Plan (RCP) dated 7/27/2020 identified R #2 wished to smoke while at the facility with interventions that directed supervise smoking. During an interview and review of the clinical record with the ADON on 10/4/2020 at 10:44 AM identified she was unable to provide documentation that R #2 ' s care plan was updated to reflect non-compliance with smoking regulations in the facility. She stated the care plan should have been updated. Review of facility Care Plans - Comprehensive Policy, dated August 2006, directed in part that care plans are revised as changes in the resident ' s condition dictate. c. R #3 ' s [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that R #3 was alert and oriented (BIMS score of fourteen out of fifteen, indicative of no cognitive impairment) and required use of a wheelchair. The smoking assessment dated [DATE] identified R #3 was a non-smoker. The Resident Care Plan (RCP) dated 8/25/2020 identified R #3 wished to smoke. Interventions directed to supervise R #3 when smoking. Review of the clinical record identified the Social Services note dated 6/24/2020 at 4:02 PM identified the social worker met with R #3 for reports of being non-compliant with smoking regulations. During an interview and review of the clinical record with the ADON on 10/4/2020 at 10:44 AM identified she was unable to provide documentation that R #3 ' s care plan was updated to reflect non-compliance with smoking regulations in the facility. She stated the care plan should have been updated. Review of facility Care Plans - Comprehensive Policy, dated August 2006, directed in part that care plans are revised as changes in the resident ' s condition dictate.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for four sampled

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) residents (R #1, R #2, R #3 and R #4) reviewed for accidents, the facility failed to ensure smoking assessments were completed timely, and for two of four residents reviewed for accidents, the facility failed to ensure searches were completed after residents were observed smoking. The findings include: Observations on 10/3/2020 at 1:20 PM identified R #1, #2, and #4 in the parking lot who were smoking without the benefit of staff supervision. Interview and observation with RN #1 on 10/3/2020 at 1:36 PM and with R #1, R #2, R #3 and R #4 identified they had extinguished their cigarettes by the time RN #1 arrived. RN #1 indicated the facility was a non-smoking facility, residents should not be smoking. Interview with the DON, RN #1 and RN #2 on 10/3/2020 at 2:45 PM identified after a resident body search, R #2 was found to have an empty box of cigarettes and a lighter on his/her person, and the items were removed by staff. R #3 and R #4 were not found to have any smoking paraphernalia. R #1 left the facility for a medical appointment with the plan that R #1 would be searched upon return to the facility. Interview and observation with the DON on 10/4/2020 at 10:30 AM identified R #4 was searched upon return from his/her appointment and was found to have a full, unopened pack of cigarettes and a lighter, and the items were removed by staff. a. R # 1 ' s [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS) assessment dated [DATE] identified that R #1 was alert and oriented (BIMS score of fifteen out of fifteen), and was non-ambulatory. A smoking assessment dated [DATE] identified R #1 was a non-smoker. The Resident Care Plan (RCP) dated 6/18/2020 identified a fall risk with interventions to lock R #1 ' s wheelchair. Review of the clinical record identified failed to identify R #1 ' s smoking assessment had been updated to reflect his/her current smoking status. Review of the clinical record identified the following: nurse ' s note dated 9/12/2020 at 2:36 PM identified R #1 was observed outside smoking and the supervisor was notified. A late entry nurse ' s note for 9/12/2020, dated 9/15/2020 at 4:51 PM identified R #1 was observed smoking in the parking lot, was verbally aggressive, and showed his/her pockets (contents). Nurse ' s note dated 9/18/2020 at 12:28 PM identified on 9/17/2020 staff observed resident smoking in front of the facility, R #1 refused to extinguish the cigarette. R #1 allowed a search of his/her bag and staff located two (2) packs of cigarettes and a lighter. Additional review of the clinical record failed to identify a resident search was completed after R #4 was observed smoking without the benefit of staff supervision on 9/12 and 9/15/2020. During an interview and clinical record review with the DON on 10/4/2020 at 10:54 AM the DON was unable to provide documentation that searches of R #4 were conducted after he/she was observed smoking without staff supervision on 9/12 and 9/15/2020. She stated that searches should have been completed. b. R #2 ' s [DIAGNOSES REDACTED]. The smoking assessment completed 2/4/2020 identified R #2 was a smoker and required supervision with smoking. The annual Minimum Data Set (MDS) assessment dated [DATE] identified that R #2 was alert and oriented (BIMS score of fourteen out of fifteen, indicative of no cognitive impairment) and required use of a wheelchair. The Resident Care Plan (RCP) dated 7/27/2020 identified R #2 wished to smoke while at the facility with interventions that directed supervise smoking. Additional review of the clinical record failed to identify a smoking assessment was completed since 2/4/2020. c. R #3 ' s [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that R #3 was alert and oriented (BIMS score of fourteen out of fifteen, indicative of no cognitive impairment) and required use of a wheelchair. The smoking assessment dated [DATE] identified R #3 was a non-smoker. The Resident Care Plan (RCP) dated 8/25/2020 identified R #3 wished to smoke. Interventions directed to supervise R #3 when smoking. Review of the clinical record identified the Social Services note dated 6/24/2020 at 4:02 PM identified the social worker met with R #3 for reports of being non-compliant with smoking regulations. Additional review of the clinical record failed to identify a smoking assessment was completed to reflect R #3 ' s wishes to smoke. d. R #4 ' s [DIAGNOSES REDACTED]. physician's order [REDACTED]. The smoking evaluation dated 2/12/2020 identified R #4 was a smoker and smoking must be supervised. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that R #4 had moderate cognitive impairment (BIMS) score of eight out of fifteen), required use of a walker for mobility, and required suctioning,[MEDICAL CONDITION] and oxygen use. The Resident Care Plan (RCP) dated 8/12/2020 identified a R #4 wished to smoke and had a history of [REDACTED]. Interventions directed to educate R #4 on smoking rules and ensure R #4 was aware of smoking policy. Additional review of the clinical record failed to identify a smoking assessment was completed since 2/4/2020. Review of the clinical record identified the following: Nurse ' s note dated 9/17/2020 at 12:45 PM identified R #4 was observed smoking outside, and R #4 gave the cigarette to staff. Social Services note dated 9/25/2020 at 2:33 PM identified the Social Worker observed R #4 smoking outside. R #4 extinguished the cigarette and denied having any smoking materials. Social Services note dated 10/1/2020 at 12:17 PM identified R #4 was observed smoking outside, and R #4 gave staff a cigarette and lighter. Additional review of the clinical record failed to identify a resident search was completed after R #4 was observed smoking without the benefit of staff supervision on 9/17, 9/25 and 10/1/2020. During an interview and clinical record review with the DON on 10/4/2020 at 10:54 AM the DON was unable to provide documentation that searches of R #4 were conducted after he/she was observed smoking without staff supervision on 9/17, 9/25 and 10/1/2020. She stated that searches should have been completed. Interview and clinical record review with RN #2 on 10/3/2020 at 2:55 PM identified smoking assessments are completed quarterly. During an interview and clinical record review with the DON on 10/3/2020 at 5:30 PM the DON was unable to provide current resident smoking assessments. She identified that although the facility was currently a no smoking facility, smoking assessments are to be current and accurate; assessments should be completed quarterly. Although no smoking assessment policy was provided for surveyor review, interview with the DON indicated that the expectation was that smoking assessments would be completed quarterly and would accurately reflect the resident ' s smoking status. Based on clinical record review, facility documentation review, facility policy review, and interviews for four sampled residents (R #1, R #2, R #3 and R #4) reviewed for accidents, the facility failed to ensure smoking assessments were completed timely, and for two of four residents reviewed for accidents, the facility failed to ensure searches were completed after residents were observed smoking. The findings include: Observations on 10/3/2020 at 1:20 PM identified R #1, #2, and #4 in the parking lot who were smoking without the benefit of staff supervision. Interview and observation with RN #1 on 10/3/2020 at 1:36 PM and with R #1, R #2, R #3 and R #4 identified they had extinguished their cigarettes by the time RN #1 arrived. RN #1 indicated the facility was a non-smoking facility, residents should not be smoking. Interview with the DON, RN #1 and RN #2 on 10/3/2020 at 2:45 PM identified after a resident body search, R #2 was found to have an empty box of cigarettes and a lighter on his/her person, and the items were removed by staff. R #3 and R #4 were not found to have any smoking paraphernalia. R #1 left the facility for a medical appointment with the plan that R #1 would be searched upon return to the facility. Interview and observation with the DON on 10/4/2020 at 10:30 AM identified R #4 was searched upon return from his/her appointment and was found to have a full, unopened pack of cigarettes and a lighter, and the items were removed by staff. a. R # 1's [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS) assessment dated [DATE] identified that R #1 was alert and oriented (BIMS score of fifteen out of fifteen), and was non-ambulatory. A smoking assessment dated [DATE] identified R #1 was a non-smoker. The Resident Care Plan (RCP) dated 6/18/2020 identified a fall risk with interventions to lock R #1's wheelchair. Review of the clinical record identified failed to identify R #1's smoking assessment had been updated to reflect his/her current smoking status. 1. Review of the clinical record identified the following: nurse's note dated 9/12/2020 at 2:36 PM identified R #1 was observed outside smoking and the supervisor was notified. A late entry nurse's note for 9/12/2020, dated 9/15/2020 at 4:51 PM identified R #1 was observed smoking in the parking lot, was verbally aggressive, and showed his/her pockets (contents). Nurse's note dated 9/18/2020 at 12:28 PM identified on 9/17/2020 staff observed resident smoking in front of the facility, R #1 refused to extinguish the cigarette. R #1 allowed a search of his/her bag and staff located two (2) packs of cigarettes and a lighter. Additional review of the clinical record failed to identify a resident search was completed after R #4 was observed smoking without the benefit of staff supervision on 9/12 and 9/15/2020. During an interview and clinical record review with the DON on 10/4/2020 at 10:54 AM the DON was unable to provide documentation that searches of R #4 were conducted after he/she was observed smoking without staff supervision on 9/12 and 9/15/2020. She stated that searches should have been completed. b. R #2's [DIAGNOSES REDACTED]. The smoking assessment completed 2/4/2020 identified R #2 was a smoker and required supervision with smoking. The annual Minimum Data Set (MDS) assessment dated [DATE] identified that R #2 was alert and oriented (BIMS score of fourteen out of fifteen, indicative of no cognitive impairment) and required use of a wheelchair. The Resident Care Plan (RCP) dated 7/27/2020 identified R #2 wished to smoke while at the facility with interventions that directed supervise smoking. Additional review of the clinical record failed to identify a smoking assessment was completed since 2/4/2020. c. R #3's [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that R #3 was alert and oriented (BIMS score of fourteen out of fifteen, indicative of no cognitive impairment) and required use of a wheelchair. The smoking assessment dated [DATE] identified R #3 was a non-smoker. The Resident Care Plan (RCP) dated 8/25/2020 identified R #3 wished to smoke. Interventions directed to supervise R #3 when smoking. Review of the clinical record identified the Social Services note dated 6/24/2020 at 4:02 PM identified the social worker met with R #3 for

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) reports of being non-compliant with smoking regulations. Additional review of the clinical record failed to identify a smoking assessment was completed to reflect R #3's wishes to smoke. d. R #4's [DIAGNOSES REDACTED]. physician's orders [REDACTED]. The smoking evaluation dated 2/12/2020 identified R #4 was a smoker and smoking must be supervised. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that R #4 had moderate cognitive impairment (BIMS) score of eight out of fifteen), required use of a walker for mobility, and required suctioning,[MEDICAL CONDITION] and oxygen use. The Resident Care Plan (RCP) dated 8/12/2020 identified a R #4 wished to smoke and had a history of [REDACTED]. Interventions directed to educate R #4 on smoking rules and ensure R #4 was aware of smoking policy. Additional review of the clinical record failed to identify a smoking assessment was completed since 2/4/2020. 1. Review of the clinical record identified the following: Nurse's note dated 9/17/2020 at 12:45 PM identified R #4 was observed smoking outside, and R #4 gave the cigarette to staff. Social Services note dated 9/25/2020 at 2:33 PM identified the Social Worker observed R #4 smoking outside. R #4 extinguished the cigarette and denied having any smoking materials. Social Services note dated 10/1/2020 at 12:17 PM identified R #4 was observed smoking outside, and R #4 gave staff a cigarette and lighter. Additional review of the clinical record failed to identify a resident search was completed after R #4 was observed smoking without the benefit of staff supervision on 9/17, 9/25 and 10/1/2020. During an interview and clinical record review with the DON on 10/4/2020 at 10:54 AM the DON was unable to provide documentation that searches of R #4 were conducted after he/she was observed smoking without staff supervision on 9/17, 9/25 and 10/1/2020. She stated that searches should have been completed. Interview and clinical record review with RN #2 on 10/3/2020 at 2:55 PM identified smoking assessments are completed quarterly. During an interview and clinical record review with the DON on 10/3/2020 at 5:30 PM the DON was unable to provide current resident smoking assessments. She identified that although the facility was currently a no smoking facility, smoking assessments are to be current and accurate; assessments should be completed quarterly. Although no smoking assessment policy was provided for surveyor review, interview with the DON indicated that the expectation was that smoking assessments would be completed quarterly and would accurately reflect the resident's smoking status.
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 observations, clinical record review, facility documentation review, facility policy review, and interviews for one of four sampled residents observed smoking for (Resident #4) who had a history of [REDACTED]. This deficient practice resulted in the finding of Immediate Jeopardy. The findings include: Resident #4's [DIAGNOSES REDACTED]. The smoking evaluation dated 2/12/2020 identified Resident #4 was a smoker, and the resident must be supervised by staff, volunteer or family at all times during smoking. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 had moderate cognitive impairment, required use of a walker for mobility, and required [MEDICAL CONDITION] care and oxygen use. The Resident Care Plan (RCP) dated 8/12/2020 identified Resident #4 expressed a desire to smoke and had a history of [REDACTED].#4 on smoking rules and ensure Resident #4 was aware of smoking policy. The physician's orders [REDACTED]. The physician's orders [REDACTED]. The physician's orders [REDACTED]. The nurse's note dated 9/17/2020 at 12:45 PM identified R #4 was observed smoking outside, and R #4 gave the cigarette to staff. The social services note dated 9/25/2020 at 2:33 PM identified the Social Worker observed R #4 smoking outside. R #4 extinguished the cigarette and denied having any smoking materials. Social Services note dated 10/1/2020 at 12:17 PM identified R #4 was observed smoking outside, and R #4 gave staff a cigarette and lighter. A review of the clinical record failed to identify a resident search was completed after Resident #4 was observed smoking without the benefit of staff supervision on 9/17, 9/25 and 10/1/2020. Observations on 10/3/2020 at 1:20 PM identified Resident #4 with a portable liquid oxygen tank attached to his/her rolling walker with oxygen connected to a venti-mask over his/her [MEDICAL CONDITION]. Resident #4 was observed to join Residents #1, #2 and #3 in the parking lot who were smoking without the benefit of staff supervision. Resident # 4 parked his/her rolling walker with the portable oxygen tank approximately five (5) feet from Residents #1, R #2 and R #3. R #4 then disconnected the oxygen tubing from his/her venti-mask (venti-mask remained over his/her [MEDICAL CONDITION]) and immediately joined the three residents smoking. Immediately after Resident #4 joined the group, Resident #1 was observed to give Resident #4 a cigarette and Resident #4 was observed to place the cigarette in between his/her lips and smoke the cigarette. Observation of the residents smoking near a portable oxygen tank and Resident # 4 with oxygen rich clothing smoking without the benefit of supervision resulted in an oxygen rich environment and a potential for a fire hazard, resulting in a finding of immediate jeopardy. In accordance with The National Fire Protection Association (NFPA) Medical Gas Cylinder Storage dated January 2018, directed in part, that smoking, open flames, electric heating elements are prohibited from within 20 feet, from gas storage. The facility Smoking Policy - Residents, dated December 2007 (without an update or revision), directed in part, the facility shall establish and maintain safe resident smoking practices and residents shall be informed about any limitations on smoking. Residents without independent smoking privileges cannot have or keep any type of smoking articles including cigarettes, tobacco except under direct supervision. The facility did not provide policy for use of oxygen when smoking. Interview and observation with Registered Nurse (RN #1) on 10/3/2020 at 1:36 P.M. identified all the residents had extinguished their cigarettes by the time RN #1 arrived. RN #1 indicated the facility was non-smoking and that some residents are non-compliant with the no-smoking regulation and smoke in the parking lot without supervision. Interview, clinical record review, and facility documentation review with the DON, RN #1 and RN #2 on 10/3/2020 at 2:45 PM identified the facility was aware that residents go outside independently and smoke. The facility hired staff to monitor the residents in the parking lot to ensure that residents do not smoke. The interview further identified two staff were assigned to supervise the parking lot on 10/3/2020, however both had called out ill and they were not replaced with any other staff, leaving the parking lot unsupervised. Interview, clinical record review, and facility documentation review with the DON, RN #1 and RN #2 on 10/3/2020 at 2:45 P.M. identified the facility had been a smoking facility (allowed residents to smoke) prior to the COVID-19 pandemic. The DON indicated that many residents who were smokers were positive for COVID-19; the facility had suspended smoking at that time and was now a non-smoking facility. Interview identified that although the facility currently had no COVID-19 positive staff or residents, and the facility was aware that residents had refused nicotine patches and expressed a desire to smoke, the facility had not changed their practice to allow resident smoking. Interview with Respiratory Therapist (RT #1) on 10/4/2020 at 10:49 A.M. identified on 10/4/2020 R #4's portable oxygen tank was set at six (6) liters to achieve 30% oxygen concentration via [MEDICAL CONDITION]. Interview with Oxygen Vendor Director of Safety and a review of manufacture recommendations on 10/5/2020 at 2:00 P.M. identified if a resident uses oxygen (02), their clothes become oxygen rich and would burn faster than clothes that have not been exposed to oxygen. She identified that any resident using oxygen should not be near any smoking or flame, and if they wanted to smoke, they need to take off the 02 and wait 15 minutes for the 02 to dissipate from their clothing to be able to smoke safely. She further identified that the 02 supply should be turned off, and any flame or smoking should be 25 feet away from the 02 supply.
F 0836 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, facility documentation review, facility policy review, and interviews for four observed residents (R #1, R #2, R #3, and R #4) reviewed for accidents, the facility failed to notify the State Agency of incidents. The findings include: a. R # 1 ' s [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS) assessment dated [DATE] identified that R #1 was alert and oriented (BIMS score of fifteen out of fifteen), and was non-ambulatory. A smoking assessment dated [DATE] identified R #1 was a non-smoker. The Resident Care Plan (RCP) dated 6/18/2020 identified a fall risk with interventions to lock R #1 ' s wheelchair. Review of the clinical record identified the following: nurse ' s note dated 9/12/2020 at 2:36 PM identified R #1 was observed outside smoking and the supervisor was notified. A late entry nurse ' s note for 9/12/2020, dated 9/15/2020 at 4:51 PM identified R #1 was observed smoking in the parking lot, was verbally aggressive, and showed his/her pockets (contents). Nurse ' s note dated 9/18/2020 at 12:28 PM identified on 9/17/2020 staff observed resident smoking in front of the facility, R #1 refused to extinguish the cigarette. R #1 allowed

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F 0836 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) a search of his/her bag and staff located two (2) packs of cigarettes and a lighter. Interview and clinical record review with the DON, RN #1 and RN #2 on 10/3/2020 at 2:45 PM identified RN #1 observed R #1 smoking in the parking lot on 10/2/2020 without staff supervision. b. R #2 ' s [DIAGNOSES REDACTED]. The smoking assessment completed 2/4/2020 identified R #2 was a smoker and required supervision with smoking. The annual Minimum Data Set (MDS) assessment dated [DATE] identified that R #2 was alert and oriented (BIMS score of fourteen out of fifteen, indicative of no cognitive impairment) and required use of a wheelchair. The Resident Care Plan (RCP) dated 7/27/2020 identified R #2 wished to smoke while at the facility with interventions that directed supervise smoking. c. R #3 ' s [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that R #3 was alert and oriented (BIMS score of fourteen out of fifteen, indicative of no cognitive impairment) and required use of a wheelchair. The smoking assessment dated [DATE] identified R #3 was a non-smoker. The Resident Care Plan (RCP) dated 8/25/2020 identified R #3 wished to smoke. Interventions directed to supervise R #3 when smoking. Review of the clinical record identified the Social Services note dated 6/24/2020 at 4:02 PM identified the social worker met with R #3 for reports of being non-compliant with smoking regulations. d. R #4 ' s [DIAGNOSES REDACTED]. physician's order [REDACTED]. The smoking evaluation dated 2/12/2020 identified R #4 was a smoker and smoking must be supervised. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that R #4 had moderate cognitive impairment (BIMS) score of eight out of fifteen), required use of a walker for mobility, and required suctioning,[MEDICAL CONDITION] and oxygen use. The Resident Care Plan (RCP) dated 8/12/2020 identified a R #4 wished to smoke and had a history of [REDACTED]. Interventions directed to educate R #4 on smoking rules and ensure R #4 was aware of smoking policy. Review of the clinical record identified the following: Nurse ' s note dated 9/17/2020 at 12:45 PM identified R #4 was observed smoking outside, and R #4 gave the cigarette to staff. Social Services note dated 9/25/2020 at 2:33 PM identified the Social Worker observed R #4 smoking outside. R #4 extinguished the cigarette and denied having any smoking materials. Social Services note dated 10/1/2020 at 12:17 PM identified R #4 was observed smoking outside, and R #4 gave staff a cigarette and lighter. e. Observations on 10/3/2020 at 1:20 PM identified R #1, R #2 and R #3 were smoking in the parking lot, without the benefit of staff supervision, when R #4 was observed to join the group. R #1 was observed to give R #4 a cigarette and R #4 was observed to place the cigarette in between his/her lips and smoke the cigarette. Interview and observation with RN #1 on 10/3/2020 at 1:36 PM and with R #1, R #2, R #3 and R #4 identified they had extinguished their cigarettes by the time RN #1 arrived. RN #1 indicated the facility was a non-smoking facility an residents should not be smoking. He further identified that some residents are non-compliant with the non-smoking regulation, and do smoke in the parking lot without supervision, against facility rules. R #1 identified he/she refused a body search by RN #1, and he/she had gotten the cigarettes from a visitor on 10/2/2020 and denied having any smoking paraphernalia. R #1 stated the cigarettes were lit by using matches he/she had, but stated that he/she has discarded them, refused to show RN #1 where they were discarded and reported that he/she did not remember where he/she discarded them. R #2, R #3 and R #4 all denied having any smoking paraphernalia. Subsequent to surveyor observations, facility staff conducted a search of R #1, R #2, R #3, and R #4. Interview with the DON, RN #1 and RN #2 on 10/3/2020 at 2:45 PM identified R #2 was found to have two empty boxes of cigarettes and a lighter on his/her person, and the items were removed by staff. R #3 and R #4 were not found to have any smoking paraphernalia. R #1 left the facility for a medical appointment with the plan that R #1 would be searched upon return to the facility. Interview further identified that R #1 and R #2 had a prior history of smoking in the parking lot. RN #1 related that on 10/2/2020 at about 7:15 PM he observed R #1 smoking in the parking lot with a visitor, he notified facility staff and directed that a search be conducted. RN #3 joined the interview and indicated that she did conduct a search of R #1 on 10/2/2020 and no smoking paraphernalia was found on R #1 on 10/2/2020. Interview and observation with the DON on 10/4/2020 at 10:30 AM identified R #4 was searched upon return from his/her appointment and was found to have a full, unopened pack of cigarettes and a lighter, and the items were removed by staff. Interview, clinical record review, and facility documentation review with the DON on 10/4/2020 at 10:54 AM identified she did not complete an incident report for any of the above incidents when residents were observed smoking without supervision, and when residents were found to have cigarettes and lighters on their person. The DON indicated that after residents were found with smoking paraphernalia, nurse ' s notes were written. Although the DON indicated that the facility did random searches after the incidents, she was unable to provide documentation that random searches were conducted prior to 10/3/2020. Interview with the DON identified there was no Accident/Incident facility policy for surveyor review, however the expectation was that the facility would follow the State Public Health Code. Review of the State Public Health Code directed in part, Class A: an event that has caused or resulted in a patient's death or presents an immediate danger of death or serious harm.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for four sampled residents (R #1, R #2, R #3, and R #4) reviewed for accidents, the facility failed to ensure the clinical record was complete and accurate. The findings include: a. R #3 ' s [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that R #3 was alert and oriented (BIMS score of fourteen out of fifteen, indicative of no cognitive impairment) and required use of a wheelchair. The smoking assessment dated [DATE] identified R #3 was a non-smoker. The Resident Care Plan (RCP) dated 8/25/2020 identified R #3 wished to smoke. Interventions directed to supervise R #3 when smoking. Review of the smoking consent form for R #3, with a notation that reflected R #3 ' s name, the form identified R #3 was a current smoke, and that R #3 refused to sign the form. Although there was a line for a witness and date, there was no witness or date recorded on the form to identify when R #3 refused to sign, and who the staff person was that identified R #3 as a current smoker. Interview and clinical record review with the DON and RN #2 on 10/4/2020 at 1:48 PM identified the smoking consent form should have been signed and dated by staff to identify who reviewed the form with R #3, and the date of the review. 1. Review of the clinical record identified the Social Services note dated 6/24/2020 at 4:02 PM identified the social worker met with R #3 for reports of being non-compliant with smoking regulations. Additional review of the clinical record failed to identify a nurse ' s note for 6/24/2020, or the seven (7) days prior, for non-compliance with smoking regulations. During an interview and clinical record review with the ADON on 10/4/2020 at 10:44 AM the ADON was unable to provide a nurse ' s note related to the 6/24/2020 non-compliance with smoking regulations. The ADON indicated that there should be a corresponding nurse ' s note to identify when the incident occurred and what the incident was. b. R #4 ' s [DIAGNOSES REDACTED]. physician's order [REDACTED]. The smoking evaluation dated 2/12/2020 identified R #4 was a smoker and smoking must be supervised. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that R #4 had moderate cognitive impairment (BIMS) score of eight out of fifteen), required use of a walker for mobility, and required suctioning,[MEDICAL CONDITION] and oxygen use. The Resident Care Plan (RCP) dated 8/12/2020 identified a R #4 wished to smoke and had a history of [REDACTED]. Interventions directed to educate R #4 on smoking rules and ensure R #4 was aware of smoking policy. Review of the clinical record identified the following: Social Services note dated 9/25/2020 at 2:33 PM identified the Social Worker observed R #4 smoking outside. R #4 extinguished the cigarette and denied having any smoking materials. Social Services note dated 10/1/2020 at 12:17 PM identified R #4 was observed smoking outside, and R #4 gave staff a cigarette and lighter. Review of the clinical record failed to identify a nurse ' s note for 9/25 and 10/1/2020 when R #4 was observed smoking without supervision. During an interview and clinical record review with the DON on 10/4/2020 at 10:54 AM the DON was unable to provide documentation that nurse ' s notes were written when R #4 was observed smoking on 9/25 and when R #4 was observed smoking and had a lighter on 10/1/2020. The DON indicated that nurse ' s notes should have been written. No facility documentation policy was provided for surveyor review, however interview with the DON identified the expectation was that the smoking consent would be filled out by staff, and nurse ' s notes should have been written.
F 0926 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Have policies on smoking.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, facility documentation review, facility policy review, and interviews for four observed residents (R #1, R #2, R #3, and R #4) the facility failed to ensure that oxygen was not used in a smoking area when the facility did not allow resident smoking, and the facility failed to develop smoking policies that reflected current facility practice. The findings include: a. R #4 ' s [DIAGNOSES REDACTED]. physician's order [REDACTED]. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075210	A. BUILDING _____ B. WING _____	**10/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WATERBURY GARDENS NURSING AND REHAB	**128 CEDAR AVENUE WATERBURY, CT 06705**

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

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F 0926 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 4) smoking evaluation dated 2/12/2020 identified R #4 was a smoker and smoking must be supervised. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that R #4 had moderate cognitive impairment (BIMS) score of eight out of fifteen), required use of a walker for mobility, and [MEDICAL CONDITION] and oxygen use. The Resident Care Plan (RCP) dated 8/12/2020 identified a R #4 wished to smoke and had a history of [REDACTED]. Interventions directed to educate R #4 on smoking rules and ensure R #4 was aware of smoking policy. Observations on 10/3/2020 at 1:20 PM identified R #4 was observed with a portable liquid oxygen tank attached to his/her rolling walker with oxygen connected to a venti-mask over his/her trach. R #4 was observed to join R #1, #2 and #3 in the parking lot who were smoking without the benefit of staff supervision. He/she parked his/her rolling walker with the portable oxygen tank approximately five (5) feet from R #1, R #2 and R #3. R #4 then disconnected the oxygen tubing from his/her venti-mask (venti-mask remained over his/her trach) and immediately joined the three residents smoking. R #4 was not observed to turn off the oxygen flow. Immediately after R #4 joined the group, R #1 was observed to give R #4 a cigarette and R #4 was observed to place the cigarette in between his lips and smoke a cigarette. Additional observation of the smoking area failed to identify any metal ashtrays, any smoking blanket, fire extinguishers or any other emergency items for fire suppression. Observation of the residents unsupervised smoking with oxygen nearby resulted in an oxygen rich environment and a potential for a fire hazard. Interview, clinical record review, and facility documentation review with RT #1 on 10/4/2020 at 10:49 AM identified R #4 ' s portable oxygen tank was set to six (6) liters. Interview and observation with RN #1 on 10/3/2020 at 1:36 PM and with R #1, R #2, R #3 and R #4 identified they had extinguished their cigarettes by the time RN #1 arrived. RN #1 indicated the facility was a non-smoking facility an residents should not be smoking. Interview and observation with the DON on 10/3/2020 at 6:30 PM identified the area where R #1, R #2, R #3 and R #4 were observed smoking had three cigarette butts on the ground. The DON indicated that the residents should not have been smoking; the facility was a no smoking facility, and the 02 should not have been used in the area when smoking occurred. Interview with Oxygen Vendor Person #1 on 10/5/2020 at 2 PM identified the company provided the facility with liquid 02 and liquid 02 was used in the portable tanks. She stated that liquid 02 at six (6) liters would cause the resident ' s clothing to become oxygen rich, causing his/her clothing be more flammable; it would burn more rapidly than someone who did not use 02. She stated that if the resident wanted to smoke the resident would need to remove the 02 and wait fifteen (15) minutes for the 02 to dissipate from the clothing to be able to smoke safely. She further stated that the 02 tank should be shut off and should be twenty-five (25) feet away from any flame or smoking for safety. Although the facility did not provide a policy for oxygen use for residents that smoke, interview with the DON indicated smoking should not occur near an oxygen source. Review of Vendor NHS Dangers of Smoking Whilst Using Oxygen Therapy guidelines, directed in part that clothing could become [MEDICATION NAME] with oxygen as you use your medical oxygen. Clothing and materials which become [MEDICATION NAME] with oxygen will burn vigorously if ignited. Clothing will continue to be [MEDICATION NAME] even after you have turned off your oxygen supply. The guidelines further directed to make sure to ventilate clothing in the open air for at least 20 minutes before smoking or going near an open flame or source of ignition, and to stay at least eight (8) feet away from any flame or potential source of ignition. Review of NFPA Medical Gas Cylinder Storage, dated January 2018, directed in part, that smoking, open flames, electric heating elements are prohibited from within 20 feet, from gas storage. b. Interview with RN #1 on 10/3/2020 at 1:36 PM identified the facility was a non-smoking facility an residents should not be smoking. Interview with the DON, RN #1 and RN #2 on 10/3/2020 at 2:45 PM identified the facility had allowed residents to smoke with supervision prior to the COVID-19 pandemic. The DON indicated that when residents were positive for COVID-19, they had identified many of those residents were smokers; the facility had suspended smoking at that time and was now a non-smoking facility. Interview identified that although residents were informed of the new non-smoking policy, the DON was unable to provide a current no-smoking policy or documentation that the residents were notified of the new non-smoking policy. Review of facility Smoking Policy Residents, dated December 2007, directed in part the facility shall establish and maintain safe resident smoking practices. Review of facility letter to residents and families, dated May 24, 2019, directed in part that residents are able to smoke with supervision only, and smoking times are 11 AM and 4 PM.