STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365823	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VISTA CENTER AT THE RIDGE	3379 MAIN STREET MINERAL RIDGE, OH 44440

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 review of the facility fire report dated 02/27/20, the State Fire Marshal's Report, facility investigations, observations of resident rooms on the 100 Wing, interviews with residents and facility staff, and medical record review the facility failed to ensure adequate lighting for one resident (Resident #41) to prevent the use of a cigarette lighter as a light source in his room at night. This resulted in actual harm that was Immediate Jeopardy on 02/27/20 at 2:40 A.M. when Resident #41 used a cigarette lighter for a light source at his bedside while he was using oxygen via nasal cannula, resulting in setting fire to his bedding and sustaining second [MEDICAL CONDITION] his face and left scapular area resulting in an emergent transfer to the local hospital for treatment. This affected one resident (Resident #41) of three residents (Resident #41, #82 and #106) reviewed for adequate lighting and accident hazards. The facility identified a total of ten residents (Residents #41, #82, #106, #135, #15, #63, #18, #97, #138, and #69) currently residing on the 100 Wing, who did not have access to a light source at the bedside. The facility census was 147. On 03/02/20 at 4:18 P.M. the Administrator, the facility Regional Administrator, and Director of Nursing (DON) were notified the Immediate Jeopardy began on 02/27/20 at 2:40 A.M. when Resident #41 who utilized continuous oxygen therapy via nasal cannula, used a cigarette lighter as a light source in his room when he had no other light source available at the bedside while trying to search for an apple in his drawer. This resulted in the oxygen igniting causing a fire at the bedside and Resident #41 suffered second [MEDICAL CONDITION] his face and left scapular region. Resident #41 was transported by Emergency Medical Services (EMS) to the local hospital for treatment. The immediate jeopardy was removed on 02/28/20 when the facility implemented the following corrective actions: On 02/27/20 at 2:40 A.M. Registered Nurse (RN) #301 and State tested Nurse Aide (STNA) #500 responded to a smoke alarm and extinguished a fire in Resident #41's room. The resident was immediately assessed [MEDICAL CONDITION] his face and EMS was called for fire and ambulance services. STNA #500 stayed with Resident #41. On 02/27/20 at 2:45 A.M., RN #301 notified Resident #41's physician of the incident. On 02/27/20 at 2:46 A.M., RN #301 notified Resident #41's family of the incident. On 02/27/20 at 3:02 A.M, fire services and EMS arrived at the facility and transported Resident #41 to the local hospital. RN #301 notified the Administrator and DON of the incident. On 02/27/20 at 3:50 A.M., the Administrator, facility Regional Administrator and Licensed Practical Nurse (LPN) #300 arrived at the facility and immediately initiated an investigation of the incident involving Resident #41. On 02/27/20 at 6:00 A.M., the management team completed whole house rooms sweeps assessing all residents for smoking materials. On 02/27/20 at 7:00 A.M., RN #301 assessed Residents #18 and #63 who resided in the room adjacent to Resident #41 and determined no negative effects for the residents. On 02/27/19 beginning at 10:00 A.M. and concluding on 02/27/20 at 6:30 P.M., in-service training was provided to all staff regarding flashlights or night lights being provided to residents on the 100 wing to facilitate having adequate lighting throughout the night. The education included the need to continue to orient residents to the use of flashlights and nightlights and to keep flashlights within reach of the residents during the night. The training was provided by Human Resource Manager (HR) #702, LPN #300, Director of Housekeeping (DHK) #703, and Dietary Manager (DM) #707. All staff (the Administrator, 12 administrative staff, nine registered nurses, 33 LPNs, 53 STNAs, three social workers, five activity staff, 20 dietary staff, and 17 housekeeping and laundry staff) received training either during an in-service at the facility or by telephone call. This was verified by review of sign in sheets. On 02/27/20 at 10:55 A.M., Resident #41 returned from the hospital and State Fire Marshals (FM) #800, FM #801 and Fire Chief (FC) #802 interviewed Resident #41 and informed the Administrator the fire was deemed accidental. On 02/27/20 at 11:00 A.M., LPN #303 and RN #304 performed a head to toe assessment of Resident #41 [MEDICAL CONDITION] the resident's face and back. The resident stated a pain level of seven out of ten. Orders were in place for [MEDICATION NAME] (antibiotic ointment) to [MEDICAL CONDITION] a new air mattress. On 02/27/20 at 11:28 A.M., RN #302 administered pain medication to Resident #41. On 02/27/20 at 11:45 A.M., Social Services Designee (SSD) #602 completed a psychosocial evaluation of Resident #41 which revealed the resident was alert, able to answer questions and said he was embarrassed by recent events. On 02/27/20 at 12:00 P.M., Corporate Maintenance (CM) #603 was contacted to discuss placing permanent overbed lighting for the 100 wing resident rooms. Electrical contractors were contacted and arrangements made to give an estimate for installation of the overbed lights. On 02/27/20 at 12:00 P.M., the Administrator notified the facility Medical Director of the incident. On 02/27/20 at 12:00 P.M. the DON updated the Daily Ambassador Rounds check sheets to include inquiries to residents about adequate lighting. The DON educated LPN #300, LPN #305, DHK #703, LPN #306, HR #702, the Administrator, Admission Director (AD) #704, LPN #307, LPN #303, Medical Records Clerk (MR) #705, Social Service Designee (SSD) #602, Social Worker (SW) #504, RN #304, SW #503, Maintenance Director (MD) #706, and Dietary Manager (DM) #707 on the updated Daily Ambassador Sheets. Each verbalized understanding of inquiring about adequate lighting including at night for all residents. On 02/27/20 at 12:40 P.M. the Administrator and LPN #300 interviewed Resident #41 regarding using a cigarette lighter and the fire in his room. Resident #41 told the Administrator he found the cigarette lighter in a bag shortly before the incident and intended to turn the lighter over to the nurse in the morning. He reported on 02/27/20 at 2:40 A.M. he started feeling funny and was looking for an apple in his nightstand. He didn't want to bother staff to turn the light switch on at the doorway and when he found the lighter decided to use it as a light source. Resident #41 stated he was not accustomed to using oxygen at night and, not thinking, ignited the cigarette lighter. Resident #41 stated he saw a quick flash of light and fire and staff responded immediately and put the fire out. On 02/27/20 at 1:00 P.M., RN #302 provided flashlights and education on the use of the flashlights to all residents residing on the 100 wing (Resident #15, Resident #18, Resident #41, Resident #69, Resident #82, Resident #97, Resident #106, Resident #135 and Resident #138). The flashlights were provided to the residents as an immediate intervention to provide an accessible light source at night while the residents were in bed. All the residents verbalized understanding of the purpose and use of the flashlights except for Resident #63 who was unable to use the flashlight. On 02/27/20 at 1:00 P.M., the DON provided a night light in Resident #63's room due to the resident's assessed inability to understand the use a flashlight. On 02/27/20 at 1:30 P.M., LPN #305 assessed Resident #15, Resident #18, Resident #41, Resident #69, Resident #82, Resident #97, Resident #106, Resident #135 and Resident #138 for their ability to use flashlights and the residents' care plans were updated to include the use of flashlights. Resident #63 was assessed and the care plan was updated to include the use of a nightlight in the resident's room. The Administrator notified the Medical Director of the utilization of flashlights and the nightlight for Resident #63. 02/27/20 at 1:30 P.M. the Administrator, DON, LPN #303, Regional Director of Operations, and Corporate Quality Assurance Nurse reviewed facility incident logs and medical records for nine additional residents (Resident #15, Resident #18, Resident #63, Resident #69, Resident #82, Resident #97, Resident #106, Resident #135 and Resident #138) residing on the 100 wing and verified none of the residents had had any incidents or accidents since 01/30/20. On 02/27/20 beginning

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

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) at 7:30 P.M., use of the updated Daily Ambassador Rounds check sheets was initiated by the Administrator and LPN #303. The Ambassador Rounds check sheets were to be completed five days a week, for four weeks and as needed and would be completed by the Administrator or their designee for all residents. On 03/02/20 at 1:00 P.M. the facility acquired battery-operated adhesive backed touch lights for all resident rooms on the 100 Wing and the DON installed the battery-operated touch lights to the headboards of the beds. On 03/02/20 at 4:30 P.M., the Administrator and DON reviewed all residents in the facility and identified no additional residents other than the ten residents (Resident #15, Resident #18, Resident #41, Resident #63, Resident #69, Resident #82, Resident #97, Resident #106, Resident #135 and Resident #138) on the 100 wing who did not have a light source accessible from their bed. On 03/03/20 at 8:30 A.M. C) #603 ordered overbed light fixtures and all necessary equipment for installation. An invoice was provided for confirmation of the order from the local supply company. On 03/03/20 from 3:15 P.M. to 3:45 P.M. observation of resident rooms on the 100 wing revealed stick on type battery-operated touch lights attached to resident headboards and handheld flashlights in all of the resident rooms except Resident #63 who had the touch light on her headboard and a nightlight plugged into the wall outlet near her bed. On 03/03/20 from 3:15 P.M. to 3:45 P.M. interviews with Resident #106, Resident #135, Resident #138 and Resident #41, who resided on the 100 Wing, revealed they had handheld flashlights and battery-operated touch lights in their rooms. They were trained on the use of the flashlights, keeping them within reach and use of the touch lights. The residents all said they had sufficient lighting in their rooms at night. On 03/04/20 at 9:45 A. M. a representative from the local electric service provider came to the facility for the purpose of determining an estimate for the cost of installation of the lighting fixtures on the 100 wing. Facility approval was pending receipt of estimate. On 03/04/20 from 10:00 A.M. to 10:22 A.M. RN #308, LPN #309, LPN #310, STNA #505 and STNA #506 were interviewed and all indicated they had participated in in-service training regarding the use of flashlights, touch lights and nightlights for residents on the 100 Wing. They verbalized understanding of the need to continue to orient the residents on the use of the flashlights and to keep them within reach at night. As of 03/04/20 at 4:30 P.M. there have been no new admissions to the 100 Wing. Going forward all new residents admitted to the 100 Wing will be provided a flashlight in their admission package. The admitting charge nurse will be responsible to verify the resident's capability and understanding for the usage of the flashlight. This will be documented in the resident's medical record. This will be monitored by the DON or designee using an audit tool daily and as needed until permanent overbed lighting is installed. Beginning on 03/04/20 at 5:00 P.M. the DON or designee will be responsible to monitor ongoing use of flashlights for all residents on the 100 Wing including flash lights in place, ability to use, understanding of usage and to address any concerns related to adequate lighting. This will be documented using an audit tool and completed daily times four weeks and as needed, or until the permanent overbed lighting is installed. Ambassador Rounds will continue on a daily basis to provide ongoing monitoring to ensure all residents in the facility have adequate lighting. Although the Immediate Jeopardy was removed on 02/28/20 the facility remained out of compliance at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was in the process of implementing their corrective action plan, including their new policy and procedure and were monitoring to ensure on-going compliance. Findings include: Resident #41 was admitted to the facility from the hospital on [DATE] with [DIAGNOSES REDACTED]. Review of the admission assessment dated [DATE] at 4:31 P.M. revealed Resident #41 had intact cognition, used a wheelchair for which he required limited assistance for transfers and was a smoker. Review of the facility Resident Tobacco Policy (dated 10/19) signed by Resident #41 on 02/25/20 revealed the resident acknowledged understanding of the facility policy prohibiting residents from keeping cigarette lighters in their rooms. Review of Care Plans dated 02/25/20 revealed Resident #41 was at risk for alterations in oxygen exchange, perfusion and impaired gas exchange related to [MEDICAL CONDITIONS] and acute and chronic [MEDICAL CONDITION] with interventions including assess lung sounds as ordered and provide oxygen as ordered. Resident #41 was at risk for injury related to smoking with interventions including smoking items to be kept at the nurse's station. On 02/27/20 care plans for Resident #41 were modified to include the use of a handheld flashlight for a light source in the resident's room, for staff to keep the flashlight within the resident's reach and encourage the resident to use the flashlight for a light source at night. physician's orders [REDACTED]. On 02/27/20 orders were added for [MEDICATION NAME] (antibiotic) ointment to wounds on face and left scapula (back of shoulder) and a nicotine patch. Review of nursing notes dated 02/27/20 at 4:00 A.M. revealed Resident #41 was found in his room with an active fire to his bed. The nurse (RN #301) and aide (STNA #500) were alerted by the smoke alarm. No smoke could be smelled in the hallway. Upon entering the room, RN #301 noticed the bed was on fire and promptly put out the fire with water from the resident's bedside pitcher. Resident #41 stated he had found a lighter and was using it to look for something in his dresser. RN #301 assessed Resident #41 and [MEDICAL CONDITION] his upper lip and nostrils as well as his upper mid back. The nurse then contacted 911. The hospital, physician, Administrator and resident's family were notified of the incident. Resident #41 was transported to the hospital by EMS. Review of nursing notes dated 02/27/20 at 9:54 A.M. revealed RN #301 spoke with the hospital who reported Resident #41 would be returning to the facility by transport with orders for [MEDICATION NAME] to [MEDICAL CONDITION] a left scapular burn. Review of nursing notes dated 02/27/20 at 10:55 A.M. revealed Resident #41 returned to the facility by ambulance and was readmitted to the facility. FM #800, FM #801 and FC #802 interviewed Resident #41 and informed the Administrator the fire was deemed accidental. Review of nursing notes dated 02/27/20 at 11:00 A.M. revealed LPN #303 and RN #304 performed a head to toe assessment of Resident #41 [MEDICAL CONDITION] the resident's face and back. The resident stated a pain level of seven on a one to ten scale. Orders were in place for [MEDICATION NAME] (antibiotic ointment) to [MEDICAL CONDITION] a new air mattress. Review of nursing notes dated 02/27/20 at 11:28 A.M. revealed RN #302 administered pain medication to Resident #41. Nursing notes dated 02/27/20 at 12:20 P.M. revealed LPN #300 and the Administrator interviewed Resident #41 who reported remorse for his actions. Resident #41 stated he found a cigarette lighter in his bag and flicked the lighter, forgetting he was wearing oxygen and stated it was like a flash. Resident #41 stated he did not wish to smoke anymore and wanted a nicotine patch. The physician was notified. A physician's orders [REDACTED].#41. Review of a facility investigation dated 02/27/20 at 3:15 A.M. revealed, on 02/27/20 at 3:15 A.M. the Administrator, the Regional Director of Operations and Regional Quality Assurance Director arrived at the facility and initiated an investigation into the fire involving Resident #41. The investigation report revealed, on 02/27/20 at 2:20 AM, RN #301 assessed Resident #41 for pain and his call light was in reach. At 2:40 A.M. RN #301 and STNA #500 heard the fire alarm go off in Resident #41's room and responded. RN #301 and STNA #500 entered the resident's room, saw a fire on the resident's bed and extinguished the fire with water from the resident's water pitcher and turned off the oxygen concentrator. Review of the Nursing Home Fire Report dated 02/27/20 revealed on 02/27/20 at 3:15 A.M. a resident (Resident #41) found a lighter and lit the lighter causing a fire in the resident's room with only the resident being injured. The fire department responded, though the fire was extinguished by facility staff. Observation on 03/02/20 at 7:09 A.M. of Resident #41's former room and current room on the 100 Wing revealed the resident had a private room with a twin bed, a window with blinds, a door to a bathroom adjoining the next room and a light fixture on the ceiling with a light switch next to the entry door. There were no overhead or ceiling mounted sources of light accessible from the resident's bed. There was a handheld flashlight on the resident's overbed table. Observations on 03/02/20 from 7:10 A.M. to 11:30 A.M. revealed Resident #41 was alert and oriented and was self-propelling about the facility in a wheelchair. The resident was appropriately dressed, well groomed, was wearing eyeglasses and had scabbing to his nose and face around his mouth. Interview on 03/02/20 at 7:45 A.M. with the Administrator and LPN #300 verified, prior to 02/27/20, Resident #41's room and the other 12 rooms on the 100 Wing only had a ceiling light with a control switch near the entry door of the resident's room. They reported there was no over bed lighting or light switches accessible to the residents when in bed. The Administrator reported, on 02/27/20 at 2:40 A.M., Resident #41 was wearing oxygen via nasal cannula in his room when he ignited a cigarette lighter near his face which caused the oxygen tubing and bedding to catch fire and [MEDICAL CONDITION] the resident's face and his left scapular region. The Administrator reported the fire triggered the smoke detector which initiated an alarm that RN #301 and STNA #500 responded to. RN #301 and STNA #500 extinguished the fire with water from the resident's water pitcher in his room. The Administrator stated RN #301 called 911 and fire and ambulance crews responded. Resident #41 was sent to the hospital for evaluation and treatment of [REDACTED]. The Administrator and LPN #300 revealed, on 02/27/20 at 3:30 A.M. the State Fire Marshals and a local fire chief arrived at the facility to investigate the fire. On 02/27/20 at 10:55 A.M., Resident #41 was readmitted to the facility with orders for an antibiotic cream to his face and back. The Administrator revealed, on 02/27/20 at 11:00 A.M. the Fire Marshals interviewed Resident #41 and determined the fire was accidental and no charges would be filed against the resident. The Administrator stated they modified their Daily Ambassador Rounds check sheets to include a question for all residents at line number #12 concerning sufficient lighting. The Administrator added

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) that flashlights had been provided to Resident #41 and all the other residents on the 100 Wing and one resident who could not use a flashlight was provided a night light next to her bed. They would monitor the effectiveness of these interventions until permanent light fixtures could be installed in all the rooms with access to turn them on at the bedside. Interview on 03/02/20 at 8:01 A.M. with RN #301 revealed on 02/27/20 at 2:40 A.M. she and STNA #500 were documenting care at the nurses' station when the call light system alarmed and indicated there was a fire in Resident #41's room. RN #301 stated she and the STNA responded to the alarm and, when they opened the door of Resident #41's room, they could see his bedding was on fire near the head board and Resident #41 was sitting up on the far side of the bed near the window. RN #301 stated she grabbed the resident's water pitcher and handed it to STNA #500 who threw the water onto the fire to extinguish it. RN #301 stated she saw Resident #41 was using oxygen and disconnected the oxygen tubing from the oxygen source and turned off the oxygen. RN #301 stated she assessed Resident #41 and left to call 911 while STNA #500 stayed with the resident in his room. She stated the fire department and ambulance arrived and Resident #41 was transported by ambulance to the hospital. Telephone interview on 03/02/20 at 10:58 A.M. with STNA #500 revealed, on 02/27/20 while sitting at the nurses' station completing documentation she heard the smoke alarm go off in Resident #41's room. STNA #500 stated she and RN #301 responded to the smoke alarm and, upon entering Resident #41's room, saw the bedding was on fire. STNA #500 stated Resident #41 was sitting at the side of his bed near the window. She stated RN #301 gave her the pitcher of water and she threw it on the fire to extinguish the flames. She stated Resident #41 told her he found a lighter and ignited it which started the fire. STNA #500 took the lighter from the resident. She stated RN #301 turned off Resident #41's oxygen then went to call 911 while she (STNA #500) stayed with Resident #41. Other nurses (LPN #311, LPN #312, LPN #313 and LPN #314) arrived to assist with the resident's care. She stated, after the fire department and ambulance arrived, Resident #41 was transported to the local hospital for evaluation. Interview on 03/02/20 at 11:30 A.M. with Resident #41 revealed on 02/27/20 sometime before 2:40 A.M., he found a cigarette lighter in his duffle bag (which had been packed by his family) and placed it in his nightstand to turn over to the nurse later in the morning. He then stated on 02/27/20 at 2:40 A.M. he was feeling like his blood sugar was low and he began looking in his bedside table for an apple he had saved from earlier that day. He had difficulty finding the apple because the only light was a ceiling light and the switch was located at the doorway. Resident #41 didn't want to bother staff to turn his light on. Resident #41 continued, while searching in the bedside table he found the cigarette lighter and forgetting he was wearing oxygen, ignited the lighter near his face to help him find the apple. He stated he then saw a flash when the oxygen tubing and bedding caught on fire. Resident #41 stated he used his hands to try to extinguish the flames when RN #301 and STNA #500 entered the room and threw water on the flames to extinguish them. Resident #41 stated he felt that his room was too dark that night with his door closed and he had no access to a light source when he was laying in his bed. On 03/03/20 from 3:15 P.M. to 3:45 P.M. observation of resident rooms on the 100 Wing revealed stick on type battery-operated touch lights attached to resident headboards and handheld flashlights in all of the resident rooms except Resident #63 who had the touch light on her headboard and a nightlight plugged into the wall outlet near her bed. On 03/03/20 from 3:15 P.M. to 3:45 P.M. interviews with Resident #106, Resident #135, Resident #138 and Resident #41 who resided on the 100 Wing reported they had handheld flashlights and battery-operated touch lights in their rooms. They were trained on the use of the flashlights, keeping them within reach and use of the touch lights. The residents all said they had sufficient lighting in their rooms at night. On 03/04/20 from 10:00 A.M. to 10:22 A.M. RN #308, LPN #309, LPN #310, STNA #505 and STNA #506 were interviewed and all indicated they had participated in in-service training regarding the use of flashlights, touch lights and nightlights for residents on the 100 Wing. They verbalized understanding of the need to continue to orient the residents on the use of the flashlights and to keep them within reach at night. Review of Daily Ambassador round sheets dated 02/27/20, 02/28/20, 03/02/20 completed by LPN #300 and LPN #305 indicated they were completed and there were no negative outcomes. Review of ongoing monitoring of flashlights for the residents on the 100 Wing completed by LPN #300 on 03/04/20 revealed no concerns with the residents not having flashlights at the bedside or not being able to use them. Review of the new admissions to 100 Wing monitoring sheets for flashlights completed by LPN #300 on 03/04/20 revealed the unit has not had any newly admitted residents since 02/27/20 This deficiency substantiates Complaint Number OH 544.