STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105935	A. Building B. Wing	05/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pensacola Nursing & Rehabilitation Center	235 West Airport Blvd Pensacola, FL 32505

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 45826 Based on observations, staff interviews, resident interviews, record reviews and policy review, the facility failed to implement smoking care plans for smoking supervision and/or assistance requirements and failed to develop a care plan for use of a smoking apron for 1 of 3 residents observed (#50) while smoking. Resident #50, who has paralysis on his left side and limited range of motion on the right, and was assessed as requiring supervision while smoking, was observed on the smoking patio with burning embers on a neck pillow around his neck from a lit cigarette, no staff was observed on the smoking patio. The facility's failure to develop and implement the smoking plan of care places residents at likelihood of serious injuries which may result in serious burns, injury and/or death and has the potential to affect all 18 residents identified as smokers, (residents #15, 19, 26, 36, 38, 49, 50, 52, 55, 58, 60, 64, 66, 70, 73, 77, 378 and 379). This situation resulted in a finding of Immediate Jeopardy at a scope and severity of K pattern. The facility Administrator was notified of the Immediate Jeopardy finding on 5/19/22 at 11:16 AM (CST). The Immediate Jeopardy was determined to have begun on 5/17/22, the day that resident #50 was observed unattended on the smoking patio with smoking coming from the neck pillow around his neck. Immediate Jeopardy was found removed on 5/19/22 when the facility provided evidence of immediate actions to remove the serious threat. The deficient practice was reduced to a scope and severity level of an E. Cross Reference F689. The findings include: On 05/17/22 at approximately 3:25 PM, the facility's smoking patio was observed. Approximately 11 residents were observed on the smoking patio and no staff were present on the patio. During this observation several residents were heard to say hey, hey, hey. At that time, the surveyor observed Resident #50, who was reclined back in a medical recliner with smoke coming from a neck pillow (a poly fiber filled, u-shaped pillow used to support the neck and head in a natural position) that was around his neck. The surveyor immediately approached resident #50 and noted a lit cigarette resting on the neck pillow. Resident #50 made no attempt to lift his upper extremities to remove the lit cigarette or to brush the hot ashes off the neck pillow. The surveyor brushed embers off the pillow at which time the lit cigarette fell to the ground and rolled under the resident's medical recliner. At this time Staff member A, Certified Nursing Assistant (CNA), arrived from inside the facility and removed the pillow from around resident #50's neck. The staff member cleaned cigarette ashes from the resident's clothing and assisted the resident with raising his left arm. A burn mark was noted on the neck pillow. (Photographic evidence obtained) (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 05/17/22 at approximately 3:28 PM, an interview was conducted with Staff member A, CNA, who reported being assigned to monitor the smoking area. When asked if resident #50 should have been wearing a smoking apron (protects a residents clothing and wheelchair from burning ash) she stated that she did not know but the resident did not like wearing the apron. The CNA then asked the surveyor which other residents on the smoke patio where required to wear a smoking apron. At this time the CNA was observed to place a smoking apron on resident #50. A record review was conducted for Resident #50 which revealed a care plan initiated on 2/25/21 with a revision date of 10/28/21 for smoking with interventions that included Will not smoke without supervision. Requires supervision for smoking. There was no notation that the resident required a smoking apron or that the resident needed assistance with smoking due to his functional limitations in his arms and hands. Review of the last smoking evaluation dated 3/3/22, indicated the resident was an unsafe smoker who needs constant supervision and needed a smoking vest (smoking apron) while smoking. The evaluation answered no to has fine motor skills needed to securely hold cigarette. Resident able to light cigarette safely with lighter, and does not allow ashes or lit material to fall while smoking. The record review further revealed that Resident #50 was admitted to the facility on [DATE] with left sided hemiplegia and hemiparesis (partial paralysis) and limited range of motion on his right side. Review of the most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident required extensive assistance with eating, locomotion, dressing, transfers and toilet use. Review of the Braden Scale for predicting pressure sore risk dated 4/3/22 stated Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. On 05/18/22 at approximately 9:02 AM, Resident #50 was observed on the smoking patio and again no staff was present on the patio. Resident #50 was reclined back in a medical recliner with a neck pillow positioned around his neck, the smoking apron was in place. The resident held a lit cigarette between his lips. Cigarette ashes were observed collecting on the left edge of the resident's neck pillow, on his left shoulder and on the medical recliner. The resident made no attempts to lift his upper extremities to brush off the ashes. The surveyor observed Staff member A, CNA, seated inside the facility's dining room, positioned at the glass door leading to the smoking patio, approximately 24 feet from the smoking residents. Resident #50 was unable to put or remove the cigarette in his mouth with his hands and did not receive assistance with smoking. On 05/18/22 at approximately 10:58 AM, Staff member A, CNA, was observed seated inside the facility's dining room by the glass door leading to the smoking patio. Resident #50 was observed on the smoking patio. Resident #50 was fully reclined in a medical recliner covered with a smoking apron. Resident #50 was observed with a lit cigarette between his lips. No staff were present to assist resident #50 with smoking safely, as he was unable to put cigarettes in his mouth or remove them by himself with his hands. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 05/18/22 at approximately 10:58 AM, an interview was conducted with Staff member A, CNA, in the facility's dining room. Staff member A stated that monitoring the smoking patio was her regular assignment, she monitors the residents from inside the facility. Staff member A stated she is not able to hear residents through the glass door separating the facility's dining room from the smoking patio. When asked how she knows when residents need assistance, Staff member A stated that residents wave their arms. She stated that the older residents educate the newer residents on how the smoking area works. She confirmed that she works 5 days a week Monday through Friday and that she does not need to leave her post by the window during her shift. The surveyor asked Staff member A to stand on the smoking patio approximately 6 feet just outside by the closed glass door, the surveyor remained inside the facility next to where the CNA observed the smoke area from. The surveyor and Staff member A attempted to speak to each other and were not able to hear each through the glass. On 5/18/22 at approximately 1:54 PM, an interview was conducted with the Director of Nursing (DON) who stated Staff A, CNA is responsible for supervising the smoking area, her hours are 8:00 AM until 6:30 PM Monday through Friday. In her absence someone from the activities department would replace her. On the weekends the weekend supervisors would assign a CNA to do the tasks. She stated that the CNA would provide assistance with what is needed according to resident assessment, She (Staff Member A) is present there, observing for safety. For the ones that need smoke aprons, ensures that they are in place. She provides lighters to the residents that can or light the cigarettes for them. In reference to resident #50, I'm aware that he spits out the cigarette. CNA should be in the area where the residents are smoking instead of the dining area because of the ones that need assistance she should be in close proximity. I am aware that Resident #50 does not have mobility on upper extremity, he needs assistance with feeding. On 05/19/22 at approximately 9:28 AM, a follow-up interview was conducted with DON and the facility Administrator. The administrator stated that she was aware the CNA was monitoring the smoking residents from behind a window but felt this was adequate because the window was clear, and that it was better than not having anyone at all. The DON stated that they were aware that resident #50 could not hold his cigarette independently but that he could hold it in his mouth really well and could spit it out on his own. She reported the resident had been doing this for about a year and there had not been issues until 2 days ago. Immediate Jeopardy was removed onsite after the receipt of an acceptable Immediate Jeopardy removal plan. The survey team verified the facility's immediate actions to remove the likely serious harm: On 5/19/22 All 18 residents who smoked were reassessed for safe smoking practices and interventions and all smoking care plans were reviewed and updated. Staff were assigned to provide stand-by assist to resident #50 while smoking and were observed to hold the cigarette up to his mouth, remove it and flick the ashes from the cigarette away from the resident. Staff designated for smoking supervision will remain in the designated smoking area at all times. The MDS Coordinator was educated on the importance of updating the care plans regarding smoking supervision and safety measures are implemented. Smoking list was updated with safe accommodations. A smoking monitoring book was developed and posted in the smoking area that provides a detailed list of all smokers, lists all safety interventions/accommodations such as aprons and stand by assist. Staff have been educated on documenting daily any concerns. The book was reviewed prior to exit without concerns. 100% of personnel in-house on 5/19/22 were educated on how to assist residents who smoke, safety while residents smoke, usage of the smoking apron, staying in the smoking area with residents at all times. Plans were in place that all staff would be educated prior to the start of their next shift.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44730 Based on observation, interviews, policy and record review, the facility failed to provide medications that meet the standard professional quality by preparing medication in advance for 1 of 5 nurses observed during medication administration observations (staff member Z). The findings include: On 5/18/22 at approximately 9:33 AM, an observation was made of Nurse Z, a Licensed Practical Nurse (LPN), standing at a medication cart on the 300-hallway talking on her personal cell phone. An observation was made of 4 medication cups with medications in each cup sitting on top of the medication cart. Each medication cup had handwritten label of a room number and a resident's last name. Nurse Z ended the phone call, apologized and stated that she was talking to her daughter who was sick. Nurse Z was then observed stacking each pre-filled medication cup one on top of the other, cupped them in her hand and proceeded into resident #57's room to administer medication. Nurse A returned to the medication cart and unstacked the remaining three medication cups and placed them on top of the medication cart. On 5/18/22 at approximately 9:40 AM, an interview was conducted with Nurse Z. Nurse Z confirmed that she had pre-pulled the medications for 4 residents (#57, #46, #33, and #52), and had taken all 4 residents' medications into resident 57's room with her. When asked if this could lead to a medication error, Nurse Z responded, yes ma'am it could. Nurse Z went on to state that she should not have pre-pulled the medication. On 5/19/22 at approximately 4:05PM, an interview was conducted with the Director of Nursing (DON). The DON stated that it was her expectation that the nurse should perform hand hygiene, to go by the medication administration record to prepare the residents' medication, administer the medication, perform hand hygiene, document the administration for one resident at a time. The DON went on to state that the nurse should not be on their personal cell phones while performing medication administration. On 5/19/22 at approximately 5:55 PM, a review was conducted of the facility's undated policy, Policy and Procedures Administration of Medication, revealed under A. General procedures completed before administering medication by any route, #1: Staff must begin by washing their hands and assembling equipment necessary for Administration of medication for one person at a time. Note, Medication may not be prepared prior to the scheduled administration time. A review of Medication Safety: Go Beyond the Basics published by [NAME] Nursing Center and retrieved from https://www.nursingcenter.com/ncblog/may-2016/medication-safety-go-beyond-the-basics, states prepare medications for one patient at a time.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 45826 Based on observations, staff interviews, resident interviews, record reviews and policy review, the facility failed to ensure adequate supervision of, and assistance for, residents who smoke tobacco products for 1 of 4 residents (#50) who required supervision while smoking. Resident #50, who has paralysis on his left side and limited range of motion on the right, and was assessed as requiring supervision while smoking, was observed on the smoking patio with burning embers on a neck pillow around his neck from a lit cigarette, no staff was observed on the smoking patio. The facility failed to implement their policy to ensure adequate supervision of residents who smoke. This had the potential to affect all 18 residents identified as smokers, (residents #15, 19, 26, 36, 38, 49, 50, 52, 55, 58, 60, 64, 66, 70, 73, 77, 378 and 379). The facility failed to implement smoking care plans which included smoking supervision requirements and failed to develop a care plan for use of a smoking apron for 1 of 3 residents observed (#50). The facility's failure to provide adequate supervision of residents while smoking and to ensure smoking places residents at likelihood of serious injuries which may result in serious burns, injury and/or death. This situation resulted in a finding of Immediate Jeopardy at a scope and severity of K pattern. The facility Administrator was notified of the Immediate Jeopardy finding on 5/19/22 at 11:16 AM (CST). The Immediate Jeopardy was determined to have begun on 5/17/22, the day that resident #50 was observed unattended on the smoking patio with smoking coming from the neck pillow around his neck. Immediate Jeopardy was found removed on 5/19/22 when the facility provided evidence of immediate actions to remove the serious threat. The deficient practice was reduced to a scope and severity level of an E. Cross reference F656 The finding include: On 05/17/22 at approximately 3:25 PM, the facility's smoking patio was observed. Approximately 11 residents were observed on the smoking patio and no staff were present on the patio. During this observation several residents were heard to say hey, hey, hey. At that time, the surveyor observed Resident #50, who was reclined back in a medical recliner with smoke coming from a neck pillow (a poly fiber filled, u-shaped pillow used to support the neck and head in a natural position) that was around his neck. The surveyor immediately approached resident #50 and noted a lit cigarette resting on the neck pillow. Resident #50 made no attempt to lift his upper extremities to remove the lit cigarette or to brush the hot ashes off of his neck pillow. The surveyor brushed embers off the pillow at which time the lit cigarette fell to the ground and rolled under the resident's medical recliner. At this time Staff member A, Certified Nursing Assistant (CNA), arrived from inside the facility and removed the pillow from around resident #50's neck. The staff member cleaned cigarette ashes from the resident's clothing and assisted the resident with raising his left arm. A burn mark was noted on the neck pillow. (Photographic evidence obtained) (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 05/17/22 at approximately 3:28 PM, an interview was conducted with Staff member A, CNA, who reported being assigned to monitor the smoking area. When asked if resident #50 should have been wearing a smoking apron (protects a residents clothing and wheelchair from burning ash) she stated that she did not know but the resident did not like wearing the apron. The CNA then asked the surveyor which other residents on the smoke patio required an apron. At this time the CNA was observed to place a smoking apron on resident #50. On 05/18/22 at approximately 9:02 AM, Resident #50 was observed on the smoking patio and again no staff was present on the patio. Resident #50 was reclined back in a medical recliner with a neck pillow positioned around his neck, the smoking apron was in place. The resident held a lit cigarette between his lips. Cigarette ashes were observed collecting on the left edge of the resident's neck pillow, on his left shoulder and on the medical recliner. The resident made no attempts to lift his upper extremities to brush off the ashes. The surveyor observed Staff member A, CNA, seated inside the facility's dining room, positioned at the glass door leading to the smoking patio, approximately 24 feet from the smoking residents. Resident #50 was unable to put or remove the cigarette in his mouth with his hands and did not receive assistance with smoking. At the time of the observation an interview was conducted with Resident #50 and Resident #49. Resident #50 stated he smokes 5 days per week, each session the facility permits. He states staff put the lit cigarette in his mouth and then they go back inside. He keeps the cigarette in his mouth the whole time he smokes because he is unable to lift his upper extremities. When asked how he removes the cigarette, Resident #50 stated, I can spit this thing 6 feet. Resident #50 stated, the facility staff monitor residents from inside the facility. Resident #49 stated he is a light smoker, and that he comes to the smoking patio frequently to check on Resident #50 to monitor his safety and to collect his discarded cigarettes. Resident #49 stated facility staff monitor from the window from inside the building but do sometimes walk around outside but then they go back inside. On 05/18/22 at approximately 10:58 AM, Staff member A, CNA, was observed seated inside the facility's dining room. Staff member A was positioned at the glass door leading to the smoking patio. Resident #50 was observed on the smoking patio. Resident #50 was fully reclined in a medical recliner covered with a smoking apron. Resident #50 was observed with a lit cigarette between his lips. No staff were present to assist resident #50 with smoking safely, as he was unable to put cigarettes in his mouth or remove then by himself with his hands. On 05/18/22 at approximately 10:58 AM, an interview was conducted with Staff member A, CNA, in the facility's dining room, the CNA was seated inside the dining area next to a set of closed glass doors which overlooked the smoking area. Staff member A stated that monitoring the smoking patio was her regular assignment and that she monitors the residents from inside the facility. Staff member A stated she is not able to hear residents through the glass door separating the facility's dining room from the smoking patio. When asked how she knows when residents need assistance, Staff member A stated that residents wave their arms. She stated that the older residents educate the newer residents on how the smoking area works. The surveyor asked Staff member A to stand on the smoking patio approximately 6 feet just outside by the closed glass door, the surveyor remained inside the facility next to where the CNA observed the smoke area from. The surveyor and Staff member A attempted to speak to each other and were not able to hear each through the glass. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 05/18/22 at approximately 11:41 AM, an interview was conducted with Resident #50. When asked if a cigarette had ever fallen on his neck pillow Resident #50 stated, it has not. When asked what he would do if that were to happen, Resident #50 stated he would remove the neck pillow using his shoulder. Resident #50 stated it would take him approximately 30 seconds to remove his neck pillow. Resident #50 was not able to demonstrate how he would remove his neck pillow. On 5/18/22 at approximately 1:54 PM, an interview was conducted with the Director of Nursing (DON) who stated Staff A, CNA is responsible for supervising the smoking area, her hours are 8:00 AM until 6:30 PM Monday through Friday. In her absence someone from the activities department would replace her. On the weekends the weekend supervisors would assign a CNA to do the tasks. She stated that the CNA would provide assistance with what is needed according to resident assessment, She (Staff Member A) is present there, observing for safety. For the ones that need smoke aprons, ensures that they are in place. She provides lighters to the residents that can or light the cigarettes for them. In reference to resident #50, I'm aware that he spits out the cigarette. CNA should be in the area where the residents are smoking instead of the dining area because of the ones that need assistance she should be in close proximity. I am aware that Resident #50 does not have mobility on upper extremity, he needs assistance with feeding. On 5/18/2022 at approximately 4:23 PM, an interview was conducted with the facility administrator who stated that her expectations for staff in the smoking area is to monitor all residents who smoke. She was asked to define monitoring Monitoring means eyes on residents where staff can react immediately. Staff are expected to ensure residents are following all assessments and report any issues to the DON. On 05/19/22 at approximately 9:28 AM, a follow-up interview was conducted with the DON and the facility Administrator. The administrator stated that she was aware the CNA was monitoring the smoking residents from behind a window but felt this was adequate because the window was clear, and that it was better than not having anyone at all. The DON stated that they were aware that resident #50 could not hold his cigarette independently but that he could hold it in his mouth really well and could spit it out on his own. She reported the resident had been doing this for about a year and there had not been issues until 2 days ago. On 05/19/22 at approximately 9:29 AM, an interview was conducted with the Therapy Manager (TM) and Staff member P, Occupational Therapist (OT). The TM stated occupational therapy does not routinely evaluate for resident smoking ability. Staff member P stated, Resident #50 was evaluated for mobility related to feeding only but that, she observed other residents putting cigarettes in Resident #50's mouth, which she deemed unsafe. Staff member P stated, OT educated the nursing staff assigned to Resident #50 that if he needs assistance with feeding due to limited range of motion Resident #50 will need assistance with everything else. A record review was conducted for Resident #50 which revealed that he was admitted to the facility on [DATE] with left sided hemiplegia and hemiparesis (partial paralysis) and limited range of motion on his right side. Review of the last smoking evaluation dated 3/3/22, indicated the resident was an unsafe smoker who needs constant supervision and needed a smoking vest (smoking apron) while smoking. The evaluation answered no to has fine motor skills needed to securely hold cigarette, Resident able to light cigarette safely with lighter, and does not allow ashes or lit material to fall while smoking (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #50's care plan initiated on 2/25/21 with a revision date of 10/28/21 revealed a smoking care plan with interventions that included Will not smoke without supervision. Requires supervision for smoking. There was no notation that the resident required a smoking apron. Review of the most recent quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident required extensive assistance with eating, locomotion, dressing, transfers and toilet use. Review of the Braden Scale for predicting pressure sore risk dated 4/3/22 stated Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. A review of the facility provided Residents Smoker's List identified 18 residents who smoke. 2 current residents (#36 and #50) were identified as requiring smoking aprons. A review of the most recent Smoking evaluations dated 3/3/22 for residents #58, #26, and#36 revealed the residents required supervision with smoking. Resident #378 had a smoking evaluation completed on 4/21/22 which noted the resident required visual supervision while smoking. On 05/18/22 at 10:17 AM, a review of the facility's Smoking - Supervised policy and procedure effective 11/30/14 and revised 2/7/20 was conducted. Review of the policy revealed For the safety of all residents the designated smoking area will be monitored by a staff member during authorized smoking times. Further review of the policy revealed The Center will have safety equipment available in designated smoking areas including smoking blankets, smoking aprons, a fire extinguishers and non- combustible self-closing ashtrays. Review of the procedure revealed If a resident is identified during the smoking evaluation to require assistance or supervision with smoking, the Center will include the appropriate information in the care plan. Further review of the procedure revealed During designated smoking times staff will be assigned to assist or supervise residents whose care plans indicate assistance or supervision is required while smoking. Immediate Jeopardy was removed onsite after the receipt of an acceptable Immediate Jeopardy removal plan. The survey team verified the facility's immediate actions to remove the likely serious harm: On 5/19/22 staff were assigned to provide stand-by assist to resident #50 while smoking and were observed to hold the cigarette up to his mouth, remove it and flick the ashes from the cigarette away from the resident. Staff designated for smoking supervision will remain at the designated smoking area at all times. All 18 residents who smoked were reassessed for safe smoking practices and interventions. Smoking list was updated with safe accommodations. A smoking monitoring book was developed and posted in the smoking area that provides a detailed list of all smokers, lists all safety interventions/accommodations such as aprons and stand by assist. Staff have been educated on documenting daily any concerns. The book was reviewed prior to exit without concerns. 100% of personnel in-house on 5/19/22 were educated on how to assist residents who smoke, safety while residents smoke, usage of the smoking apron, staying in the smoking area with residents at all times. Plans were in place that all staff would be educated prior to the start of their next shift.