STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING _____ B. WING _____	C 10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOKOMO HEALTHCARE CENTER	429 W LINCOLN RD KOKOMO, IN 46902

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F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00418161 and IN00418728. Complaint IN00418161-No deficiencies related to the allegations were cited. Complaint IN00418728-Federal/State deficiency related to the allegations is cited at F689. Survey date: October 12, 2023 Facility number: 000127 Provider number: 155222 AIM number: 100291430 Census bed type: SNF/NF: 73 Total: 73 Census payor type: Medicare: 5 Medicaid: 51 Other: 17 Total: 73 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on October 20, 2023.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		

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

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F 689	Continued From page 1 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a smoker was supervised while smoking at an unauthorized smoking time when her oxygen tank caught on fire for 1 of 3 residents being reviewed for smoking accidents. (Resident B) The deficient practice was corrected on 10/2/23, prior to the start of the survey, and was therefore past noncompliance. Finding includes: A document, titled "Indiana State Department of Health Survey Report System," dated 10/12/23, indicated on 10/1/23 at 3:37 p.m., Resident B was outside on the patio with her portable oxygen tank, when it sparked and began to smoke. Staff was alerted and immediately responded by extinguishing the oxygen tank to ensure the resident's safety. The portable tank was not touching the ground and was appropriately placed on the back of the resident's wheelchair. At no time was the resident exposed to the smoking portable tank. Through the facility's investigation, it was discovered another resident was in the same vicinity. Both residents were moved to a safe location. During an interview, on 10/12/23 at 10:56 a.m., Resident B indicated she did not remember the date or time of the oxygen incident. She knew it was after the last smoking break time, so it had to be after 9:00 p.m. She and another resident were	F 689	Past noncompliance: no plan of correction required.	

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outside on the back patio where the residents go to smoke, smoking by themselves. For some reason, she had two portable oxygen tanks on the back of her wheelchair. She usually shut her oxygen tank off but left her cannula in her nose when she went out to smoke. She thought she had turned her oxygen tank off, but she must have tuned the second tank on instead of turning the first one off. She was smoking her cigarette and next thing she knew, the other resident, who was smoking outside on the patio with her was "ripping" the oxygen tubing out of her nose and telling her to get up away from her wheelchair. Then, he ran into the facility to get a staff member to come help put the fire out. She indicated the other resident saved her life by removing her oxygen from her face. She did not go out to the smoking times at 8:00 a.m., and 10:00 a.m., but she did go smoke at the other times, which were at 1:00 p.m., 3:30 p.m., 6:00 p.m., and the last one was at 9:00 p.m. When asked how she obtained the cigarettes and lighter to go out and smoke at an undesignated smoking time and how did she get out the locked door, she indicated she snuck a few cigarettes out of her pack before she had to hand them back to the facility staff, she already had an extra lighter and the other resident she went outside with knew the code to get out onto the patio. She indicated even if residents did not know the code, all they had to do was hold the door handle for 15 seconds then the door opened. There was a red button on the outside of the door on the patio they pushed to shut off the sounding alarm once the door opened. They pushed the same red button to let them back in the facility after they were finished smoking.

On 10/12/23 at 11:27 p.m., the Maintenance Director was observed changing the door code on

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the keypad to the door to the patio. At that time, he indicated Resident B and another resident was outside smoking at 1:30 a.m., on 9/29/23, when Resident B's portable oxygen tank caught on fire. A staff member took a fire extinguisher from the West hallway outside to the patio and used it to put the fire out. He changed the code to the door that day and had changed it several times since then. Whenever he got word, a resident may know the code to the door he changed the door code.

A review of a list of the current smokers in the facility indicated Resident B was on the list of current smokers. The names of the residents with oxygen were highlighted in pink and Resident B's name was highlighted in pink.

The record review for Resident B was completed on 10/12/23 at 12:45 p.m. Diagnoses included, but were not limited to, type II diabetes mellitus, chronic obstructive pulmonary disease, tobacco use, difficulty in walking, and anxiety disorder.

Resident B had a care plan which addressed the problem she was non-compliant with the facility smoking policy. Interventions included, but were not limited to, 5/31/22, behavioral health consults as needed, 8/22/23, communicate with resident/resident representative regarding behaviors and treatment.

Resident B had a care plan which addressed the problem she had a behavior problem of smoking with oxygen on and not following the smoking policy. Interventions included, but were not limited to, 7/25/23, behavioral health consults as needed, 7/25/23, communicate with resident/resident representative regarding behaviors and

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treatment, and 7/25/23, document resident's behaviors (verbal and physical) and all nursing/physician actions.

A review of the current smoking times provided by the Executive Director (ED) on 10/12/23 at 12:15 p.m., indicated the smoking times were at 8:00 a.m., 10:00 a.m., 1:00 p.m, 3:30 p.m., and 6:00 p.m. At that time, the ED indicated there were no independent unsupervised smokers anymore. She had spoken to the ombudsman to ask him what she should do to prevent Resident B from smoking with her oxygen on and he suggested stopping the independent unsupervised smoking times and make all the smokers smoke at supervised smoking times, so this was what she did.

On 10/12/23 at 3:30 p.m., an attempt to contact the other resident who was outside smoking with Resident B was made and there was no answer and there was no way to leave a message.

Pictures of the burnt oxygen tubing and oxygen tank were reviewed on 10/12/23 at 4:17 p.m., after being provided by the Vice President of Risk Management and Performance Improvement. The oxygen tubing where it connected into the portable oxygen tank was melted and black. The top of the oxygen tank where the oxygen tubing connected to the portable oxygen tank was black and melted. The strap which connected to the portable tank was burned off the tank. The area above the knob to dial in how much oxygen the resident would have gotten was black. The metal port where the oxygen tubing connected to the portable oxygen tank was black on the inside surrounding the port.

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During a phone interview, on 10/12/23 at 4:35 p.m., QMA 4 indicated she was at the central nurses' station when a resident came up to her and told her Resident B fell asleep with her head on her chest, with her cigarette in her hand, and her cigarette fell onto her oxygen tank and burnt her oxygen tank. The male resident indicated he saw a green spark like a firecracker prior to the flames starting. When she got out to the patio where the smokers smoke at, she observed flames coming from the back of Resident B's wheelchair. The resident was standing by the back of her wheelchair trying to get her cigarettes and her bag off the back of it. Her wheelchair was sitting in the corner of the patio. The other resident was trying to get her into the building to safety. QMA 4 got both the residents into the facility, then went to the West hallway to get a fire extinguisher and put the fire to the back of the wheelchair and oxygen tank out. The fire was at the top of the oxygen tank where the oxygen attaches to the tank and the strap for the tank was located. Her wheelchair was also burnt. Resident B had to be given a new wheelchair. QMA 4 indicated the male resident who had been outside smoking with Resident B had since passed away after he was discharged from the facility, and he was not able to be interviewed.

During a phone interview, on 10/12/23 at 5:06 p.m., RN 5 indicated Resident B indicated to her she was smoking with her oxygen on with another resident on the patio, when her oxygen tank caught on fire. The fire incident happened around 1:00 a.m.

A current policy, titled "Resident Smoking Guidelines," undated, provided by the ED on 10/12/23 at 12:15 p.m., indicated

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F 689	Continued From page 6 "...Definition...Supervised Smoker: a resident is unable to demonstrate safe smoking habits including smoking material management, lighting, controlling cigarette ash extinguishing smoking materials and requires staff supervision when smoking. Policy...Residents will be assessed by the interdisciplinary team (IDT) and designated 1) independent or 2 (supervised...Procedure: 1. Assessment, observation, and designation of independent or supervised smoker will be made by the IDT team for each resident who requests to smoke in the facility. a. Complete the Smoking Assessment upon admission, quarterly, and with a significant change in condition...5. Smokers will be permitted to smoke only in designated smoking areas a. For Supervised Smokers: smoking times will be posted by the facility...8. Facility staff will: a. Secure smoking materials in a locked area when not in use by the resident/patient for both independent and supervised smokers...9. Smoking safety instructions for all smokers will include a. All smoking materials will be maintained by the facility staff and provided to the resident/patient on request. b. smoking will only be in designated areas. c. Smoking materials will be returned to the facility staff upon completion of smoking. d. Noncompliance with the smoking policy may lead to discharge notification. e. Supervised smoking will be performed by a staff member...." A current policy, titled "Oxygen Therapy Safety Standards," undated, provided by the ED on 10/12/23 at 12:15 p.m. indicated "...Policy...The purpose of this policy is to provide guidance for the safe use, transport and storage of oxygen as well as understand the unique properties of liquid oxygen...Procedure: 1. Oxygen Safety Standards and Precautions...b. These standards address	F 689		

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the dangers of fire, as well as physical injury from oxygen and its containment vessels. c. Oxygen is an element that, that at atmospheric temperatures and pressures, exists as a colorless, odorless, tasteless gas...c. Oxygen is a non-flammable gas but supports combustion and can accelerate burning when flames/fire/sparks are present. 1. When a resident is using oxygen therapy, whether by mask or nasal cannula or other device, small amounts of oxygen leak out and around the device creating an oxygen-rich environment immediately surrounding the area nearest the resident. 2. The area near and around a resident using oxygen will support and accelerate burning. 3. In the presence of an ignition source (fire, sparks) and a fuel (paper, clothes etc.), oxygen will vigorously accelerate combustion. 4. Materials that normally will not burn in air, may burn in air, may burning an oxygen-enriched atmosphere. 5. Materials that do burn in air, will burn more vigorously and at a higher temperature in an oxygen enriched atmosphere. 6. Since fires can ignite more readily in an oxygen-enriched atmosphere, and these fires burn explosively, it is extremely important that fire prevention measures are taken to ensure safety...h. No smoking: smoking is prohibited in all areas where oxygen is stored, transported or used...q. Open flames will not be permitted in an oxygen administration area, this includes fires for cooking, gas heating appliances, candles, oil lamps, electric radiant heaters etc. r. Residents, nursing agency personnel/caregivers and families must be educated regarding the safe use of oxygen use...No flames (smoking, candles, etc.) when oxygen in use...."

This deficient practice was corrected by 10/2/23, after the facility implemented a systemic plan that

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included the following actions: Both residents were immediately assessed for injury. Both portable oxygen tanks were replaced. Both residents were educated on the designated smoking times. Both residents were educated on safe smoking and oxygen safety. The facility implemented a smoking monitor to sit outside the patio door for the 10 p.m. to 6 a.m., daily time frame. The code to the door in the designated smoking area was changed on 10/1/23. The facility conducted an audit of all portable oxygen tanks to ensure they were in good working order and had no evidence of malfunction. The facility conducted a search of residents' rooms with their consent for smoking materials and secured them in the lock boxes if found. The facility educated all smokers utilizing the Resident Smoking policy with emphasis on designated smoking times and oxygen safety. The residents were educated on reporting to staff any signs of portable oxygen tank malfunctions with emphasis leaking tanks, smoking tanks, squealing tanks, or flames. The facility competed 100% education with all staff utilizing the Resident Smoking policy and Oxygen Safety policy with emphasis on designated smoking times, providing supervision, removing oxygen/storing oxygen while smoking and fire safety and prevention The facility will conduct weekly fire drills on each shift for four weeks to ensure fire safety protocol is met on all shifts and staff have a clear understanding of roles and responsibility during a fire. The Director of Nursing or Designee will observe five residents each week for four weeks, then three residents each week for four weeks, then one resident each week for four weeks to ensure residents are supervised during designated smoking times and no oxygen is in the designated smoking area and all portable oxygen tanks appear to be in good

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F 689	Continued From page 9 working order. The results of the audit observations will be reported, reviewed, and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months, then randomly thereafter for further recommendations. This Federal tag relates to Complaint IN00418728. 3.1-45(a)(2)	F 689		