The following reflects the findings of the Department of Public Health during a Complaint Investigation visit:

CLASS A CITATION – PATIENT CARE
22-3146-0014881-F
Complaint(s): CA00610399

Representing the Department of Public Health:
Surveyor ID # 3146

The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility.

F689 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
§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 identify and remove

This Plan of Correction is the response by Laguna Honda Hospital and Rehabilitation Center ("Laguna Honda" or "facility") as required by regulation, to the Statement of Deficiencies and Plan of Correction (CMS-2567) issued by the California Department of Public Licensing and Certification on March 14, 2019; and received by the facility on March 14, 2019; for an abbreviated survey and investigation conducted for Facility Reported Incident (FRI) No. CA00610399 that was initiated on November 2, 2018, and concluded on November 10, 2018. The submission of this Plan of Correction does not constitute an admission of the deficiencies listed in the Summary Statement of Deficiencies or an admission to any statements, findings, facts, and conclusions that form the basis of the alleged deficiencies.

Laguna Honda maintains an environment that is free of accident hazards as possible; and provides each resident with adequate supervision and assistive devices to prevent accidents. The facility has developed written policies and procedures, and implemented and maintained a high fire safety program standards for the prevention of fire and the protection of life and property.
risks for fire with 1 of 763 residents (Resident 1) when:
1) Resident 1 was injured while smoking in bed with oxygen on.
2) Resident 1 personal belonging were not inventoried for ignitable/combustible items
   Resident 1 suffered burns to face, nose left arm from the shoulder down to the elbow and
   significant smoke inhalation. He underwent two surgeries for skin debridement, removal of
   dead or damaged tissue) and skin graft (application of skin replacement).
   This failure caused significant physical injury to
   Resident 1 and had the potential to cause
   significant harm or death to other residents,
   visitors and staff.

Findings:
Resident 1 had been a long-term resident at
the facility since 1/14/2009 and was recently
re-admitted on 9/11/18 after having surgery on
his neck with a primary diagnosis of
hemiparesis (paralysis to one side of the body).
Prior to re-admission, Resident 1 was capable
of ambulating by wheelchair off the unit and
smoked regularly.

Review of Resident 1's Minimum Data Set
(MDS, a resident assessment tool) dated
10/19/18 indicated Resident 1 had no cognitive
impairment, range of motion was impaired on
both sides for upper and lower extremities
requiring extensive assistance for activities of
daily living and diagnoses included but were not
limited to Chronic Obstructive Pulmonary
Disease (COPD, a breathing disorder) requiring
oxygen therapy, anxiety, depression and

On 10/31/2018 at 2324, Nursing staff responded immediately to a fire alarm, extinguished the fire, removed the resident from the room and called 911. The San Francisco Fire Department arrived at the facility at approximately 2340, assessed the room where the fire occurred and cleared the fire alarm at approximately 2345. The resident was assessed by the on-call physician and transferred to the acute care hospital for further evaluation and treatment.

Resident 1 was re-admitted to the facility on 12/5/2018 and an inventory of his personal belongings has been completed. The resident no longer has ignitable/combustible items at his bedside.

Other residents who are admitted or re-admitted to the facility will have an inventory of their personal belongings completed, notified of the new fire safety standard not to have ignitable/combustible at bedside, and have such items collected for safekeeping by Nursing staff.

On 11/30/18 and on-going
chronic pain. Review of Resident 1 Care Plan titled "At risk for Nicotine Dependence" dated 9/11/18 indicated a goal that Resident 1 would not smoke on the facility campus. Interventions indicated a nicotine patch was administered, observe for signs and symptoms of nicotine withdraw, a smoking assessment was completed and education on the risks while smoking on O2 provided.

Review of Resident 1 Care Plan titled "Ineffective Airway Clearance due to COPD Dx (breathing disorder)" dated 9/12/18 indicated "Administer O2 (oxygen) as ordered by MD" and "Monitor VS (vital signs) and O2 saturation Q (every) shift and notify MD (physician) for any abnormal findings".

Review of Resident 1 record titled "Admission Nursing Assessment" dated 9/11/18 indicated "Vital Signs/Ht./Mt. ... Comments: 100% O2 sat on 2L/min via NC (nasal canula)"

During an interview on 11/2/18 at 11:19am Quality Management Nurse (QM1) stated on 10/31/18 at approximately 11:29am a fire erupted in the room of Resident 1. Registered Nurse (RN1) used a fire extinguisher and extinguished the fire. Resident 1 was taken to a general acute care hospital (GACH1) and Resident 1's roommates were evacuated to the great room and examined by the facility MD. RN1 was taken to a general acute care hospital (GACH2) and treated for smoke inhalation. During observation on 11/2/18 at 11:45am of Resident 1's room, there was a 4 ½" diameter of

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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<td>F689</td>
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<td>Nurse Managers or their designee provided other resident smokers education on not smoking inside the hospital building (all rooms and bathrooms), and when oxygen is in use as it poses a fire hazard and puts all at risk. Resident smokers were also told not to give, share, trade or sell smoking materials or lighters. Nursing Directors are responsible for monitoring compliance that resident education was provided.</td>
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<td>On 11/9/2018, the Chief Nursing Officer directed the Nursing Operations Manager to instruct Nursing staff to conduct a clinical room search for residents who are currently on oxygen and remove any and all smoking materials for safe keeping and to prevent the risk of another fire incident. Respective Unit Nurse Managers are responsible for monitoring the completion of this task by creating a list of residents who are currently on oxygen who had their smoking materials removed for safe keeping.</td>
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<td>The facility has adopted a new fire safety standard of not allowing residents to keep lighters, matches and electronic cigarettes at the bedside via Memo to all staff.</td>
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Event ID: SDMU11

3/14/2019 9:02:28AM

Doc accepted 3/14/19 @ 5:10pm
black melted material on the floor by the far wall where the head of bed was located. The walls and ceiling appeared clean and without fire damage. The bed appeared new. During concurrent interview, when asked if anything had been done to the room, the Nurse Manager (NM1) stated the damaged bed had been removed to the facilities basement for disposal and environmental services had been called to clean the room. They suspect it was a cigarette that started the fire.

During an onsite visit in the facilities building on 11/2/18 at 12:10pm, the bed from the fire was observed burned on the left upper quadrant. The fire burned through the fire protectant covering of the mattress, melted part of the left side-rail and scorched a bed control chord.

During an interview on 11/2/18 at 2pm the Case Manager(CM1) from the GACH1 stated Resident 1 was intubated (a tube placed in airway for breathing) and had third degree full thickness burns to left upper extremities, face and neck. Resident 1 would be having surgery for a skin debridement (removal of dead or damaged skin) and skin graft (application of donated skin for wound healing).

Review of GACH1 ED (Emergency Department) Physician Notes for Resident 1 dated 11/1/18 @ 2:55am indicated "(Name of attending Physician)… Resident arrived to ED by ambulance on 11/1/18 at 12:31am… Noted to have smoked in bed & caught on fire… noted burn to face and nose… burn on the left arm from the shoulder down to the elbow… respiratory distress… significant smoke."

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<td>Resident lighters, matches, electronic cigarettes, and other items known to pose a risk of igniting a flame when in close proximity to an oxygen delivery system have been collected by staff for safekeeping. Residents who are determined to be safe smokers, and those who are non-smokers were asked to voluntarily turn in their lighters, matches, electronic cigarettes and other items known to pose a risk of igniting a flame to Nursing staff for safekeeping. Staff conducted a clinical safety search of resident rooms and the belongings of residents who are determined to be an unsafe smoker, use oxygen, and or pose a fire safety risk, and secure their smoking materials and other items that may pose a safety hazard. Resident smokers have been re-assessed using Form MR 161 and determined if they are a safe or unsafe smoker, and a new or revised smoking care plan developed based on new standards were completed by Nurse Managers or their designee. Nursing Directors are responsible for monitoring compliance that resident smoking re-assessments and a new or revised resident care plan have been completed through quality audits (QAs).</td>
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inhalation injury...decision made to intubate.* Review of GACH 1 Operative Report for Resident 1 dated 11/8/18 indicated a skin debridement (removal of dead or damaged skin tissue) and skin graft (application of skin replacement) surgical procedure was done on the left shoulder and bilateral upper extremities. Estimated blood loss during the procedure was 500mL; Resident 1 received one unit of blood during the procedure. Review of GACH 1 Operative Report for Resident 1 dated 11/12/16 indicated the resident underwent surgical procedures for skin debridement and skin grafts were completed for the upper extremity and shoulder. Skin was grafted from the bilateral thighs. Estimated blood loss during the procedure was 300mL; Resident 1 received on unit of blood during the procedure.

During an interview on 11/7/18 at 2:50pm, the Patient Care Assistant (PCA1) stated on 10/31/18 he was assigned to care for Resident 1 who always requested to have his backpack on the bed at his left side. When asked what was in the backpack or why Resident 1 wanted the backpack on the bed at his left side, PCA1 stated "I do not know, I didn't ask, that was his personal property and didn't think it was right to know".

During an interview on 11/9/18 at 9:58am RN1 stated she was giving report on 10/31/18 at 11:23pm in the meeting room by the nurses' station when she heard the fire alarm go off. RN1 and the nurse she was reporting to split up and went in different directions to see what

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| P689 | The new fire safety standard has been communicated to residents, families, staff, volunteers and visitors at various meetings including Resident Council, neighborhood Community meetings, and various departmental staff meetings. Signage on the new safety standard has been posted throughout the hospital building for the benefit of family members, visitors, volunteers, residents and staff. Laguna Honda staff were directed to complete an in-service in response to the fire to learn about the new fire safety standard and sustain the above corrective actions. A read and sign in-service covered the following topics:
  a. The new fire safety standard of not allowing residents to keep lighters, matches, electronic cigarettes, and other items known to pose a risk of igniting a flame at the bed side;
  b. Conducting a thorough inventory of resident belongings on admission, readmission and relocation;
  c. Preventing fire incidents from unsafe smoking including safety measures for oxygen use, safe criteria for resident smoking, completing Form MR 161, monitoring resident compliance with safe smoking practices, conducting a respectful and lawful clinical search when indicated; and

triggered the fire alarm. RN1 went to the bathrooms at the end of that hall first, stating that sometimes residents will try smoking in the bathroom and trigger the fire alarm. When no one was found in the bathroom and there was no smell of smoke, RN1 headed to the N1 hallways named Cypress and Juniper when RN1 heard a Personal Care Assistant (PCA2) screaming that Resident 1 was on fire. RN1 started running towards Resident 1's room and saw a Home Health Aide (HHA) located outside Resident 1's room screaming "the patient is on fire". A Registered Nurse (RN2) ran out of Resident 1's room screaming "(Resident 1) is on fire". RN1 stated as she entered the room it was filled with black smoke, she could barely see the resident and the flames were approximately 3' high. RN1 called out to Resident 1 who responded by saying "help me I can't breathe". RN1 grabbed the fire extinguisher from the hallway outside the room and extinguished the flames. RN1 stated because of the smoke it was difficult to see and breathe. It was difficult to release the bed brake and disconnect the oxygen and tube feeding to evacuate Resident 1 so RN1 kept trying to reassure Resident 1 of her presence. RN1 exited the room twice to gasp for fresh air and call for help, yelling out to staff to call 911 and Code Blue. The HHA and Nursing Supervisor (NS1) entered the room and assisted RN1 with releasing the bed brake and disconnecting the oxygen tube and feeding tube and evacuating the patient to the great room. RN1 sat down and placed herself on 6 liters of oxygen by the

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Event ID:6DMU11

POC accepted 3/14/19 at 5:10pm

State-2567
nursing station while having difficulty breathing and realized while seated she was covered in "white stuff" from the fire extinguisher and ash. RN1 was taken to General Acute Care Hospital (GACH2) by ambulance and treated for a smoke inhalation injury.

During an interview on 11/7/18 at 11:30am a Quality Management Nurse (QM1) stated that after the fire staff looked through Resident 1’s personal belongings and found a backpack with a lighter, USB charger for an e-cigarette and a paper match stick.

Review of Resident 1’s medical record indicated no inventory record of personal belongings upon re-admission to the facility on 9/11/18. During an interview on 11/21/18 at 11:12am NM1 stated a personal belongings inventory list is completed if a resident was gone from the facility for longer than a seven day bed hold. Resident 1 was discharged to the GACH1 on 8/31/18 and re-admitted on 9/11/18. "We should have completed a personal belongings inventory list".

Review of the policy and procedure titled "HANDLING RESIDENT’S PROPERTY AND PREVENTION OF THEFT AND LOSS" dated 7/14/15 indicated “1. General Guidelines a. Upon admission, relocation, annually, and transfer or discharge from (facility name), nursing staff and the resident and/or his/her representative shall complete an inventory of the resident’s property.”

During an interview on 11/7/18 at 4:18pm, when asked if patients can keep lighters at the bed side, the Director of Quality Management

Resident smoking violations and the removal of resident smoking materials for safekeeping are tracked by Risk Management Nurses. A monthly report will be aggregated and submitted to the Skilled Nursing Performance Improvement and Patient Safety Committee for their review. The Quality Management Nurse Manager is responsible for compliance with monthly reporting. The Chief Nursing Officer and the Director of Quality are responsible for directing on-going improvement action plans for safe resident smoking behaviors and the prevention of fire and the protection of life and property.
(DQM) stated "It has always been the policy (name of the facility) is a smoke free campus, but residents can keep items in their room. They are assessed to determine if they are a safe or unsafe smoker, provided education and if they are an unsafe smoker then their personal items can be confiscated and they can lose their smoking privileges." Staff completes an MR 161 Form titled "SMOKING ASSESSMENT AND PLAN OF CARE" for every new admission. Completion of this form assists the staff in determining whether a resident is a safe or unsafe smoker.

Review of Activity Progress Notes dated 10/10/18 at 3:42pm indicated Resident 1 "likes to self-stroll off unit to smoke cannabis by himself at the bus shelter away from everyone."

Review of facility policy and procedure "SMOKE and TOBACCO FREE ENVIRONMENT" dated 9/11/18 indicated "POLICY: ...2. This policy applies to smokeable and tobacco products, including e-cigarettes, nicotine, non-nicotine and chewing tobaccos, ...vi. Assessment and education about smoking and smoking cessation shall be documented in the resident's medical records."

During an interview on 11/15/18 at 2:50pm a Fire Inspector stated "damage was noted to the left side upper portion of the bed. (RNI) informed him the resident was smoking in bed". An IJ was declared on 11/17/18 at 4:18pm in the presence of the Director of Quality Management (DQM), Nursing Director (ND1), Quality Management Nurse Manager (QM1), Nurse Manager (NM1), Risk Management
Nurse(RM1) after Resident 1 sustained
The facility submitted an acceptable Plan of
Correction that included but not limited to the
following:
1) Resident education on hospital policy and
procedure and the risks/dangers of smoking
inside the hospital building while on oxygen
2) Re-assessment of smokers to determine if
they are safe or unsafe smokers, new/revised
care plans
3) Education and Implementation of a new Fire
Safety Standard
4) Monitoring Compliance of new Fire Safety
Standard

The implementation of resident education and
re-assessment was verified and confirmed and
the IJ was lifted on 11/10/18 at 1:40pm in the
presence of the Executive Administrator (EA),
Chief Nursing Officer (CNO), Nursing Director
(ND1), Manager of Administration, Assistant
Hospital Administrator, Chief Medical Officer,
Quality Management Nurse Manager (QMN1),
Risk Management Nurse (RM1).

Therefore, the facility failed to identify and
remove risks for fire with 1 of 783 residents
(Resident 1) when:
1) Resident 1 was injured while smoking in bed
with oxygen on.
2) Resident 1 personal belonging were not
inventoried for ignitable/combustible items.
This failure caused significant physical injury to
Resident 1 and had the potential to cause
significant harm or death to other residents.
visitors and staff. The deficient practice presented either imminent danger that death or serious harm would result or a substantial probability that death or serious physical harm would result.