STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175542	A. BUILDING _____ B. WING _____	C 12/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANCED HEALTH CARE OF OVERLAND PARK	4700 INDIAN CREEK PARKWAY OVERLAND PARK, KS 66207

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS00184548 and KS00184552. On 12/13/23 at 04:04 PM the facility recived a copy of the "Immediate Jeopardy [IJ] Template" and was informed of the IJ for Resident (R)1. R1 admitted to the facility on 12/08/23 at approximately 01:00 PM. R1 was alert and oriented to person place time and situation and received oxygen via nasal cannula at six liters per minute (LPM). At 05:15 PM on 12/08/23, Certified Nurse Aide (CNA) M took R1 outside for a cigarette break while R1 wore his oxygen. CNA M locked R1's wheelchair brakes and went back inside. Between 05:26 PM and 05:29 PM, R1 lit his cigarette. Around 05:34 PM R1's nasal cannula ignited. R1 removed the nasal cannula, shook it, and attempted to put out the flame. At approximately 05:35 PM, Licensed Nurse (LN) H approached the facility for her scheduled shift. LN H observed R1 swinging the nasal cannula tubing around and trying to put out the fire. LN H disconnected the tubing from the oxygen cylinder on the back of the wheelchair and turned off the oxygen flow. R1 sustained facial burns and later became hypoxic (insufficient oxygen), which required emergent treatment. The failure placed R1 in immediate jeopardy. The facility completed the following corrective actions by 12/11/23: The smoking policy was updated, and the facility has changed to a non-smoking facility with smoking residents that were already admitted grandfathered in.	F 000		

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

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F 000	Continued From page 1 The two smoking residents had a safety smoking assessment completed on 12/09/23. The Nurses have received training related to asking the residents about smoking and performing the smoking assessment even though the facility is no longer a smoking facility to assure safety. The facility staff received training related to smoking safety on 12/11/23 The corrective actions were completed prior to the onsite survey therefore the citation was issued as past noncompliance at the scope and severity of "J." The 2567 was sent electronically on 12/20/23.	F 000		
F 689 SS=J	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: The facility identified a census of 38 residents. The sample included three residents reviewed for accidents. Based on record review, interview, and observations, the facility failed to identify hazards and implement adequate supervision and care to ensure safe smoking for Resident (R) 1. R1 admitted to the facility on 12/08/23 at approximately 01:00 PM. R1 was alert and oriented to person place time and situation and	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 2	F 689		

received oxygen via nasal cannula at six liters per minute (LPM). At 05:15 PM on 12/08/23, Certified Nurse Aide (CNA) M took R1 outside for a cigarette break while R1 wore his oxygen. CNA M locked R1's wheelchair brakes and went back inside. Between 05:26 PM and 05:29 PM, R1 lit his cigarette. Around 05:34 PM R1's nasal cannula ignited. R1 removed the nasal cannula, shook it, and attempted to put out the flame. At approximately 05:35 PM, Licensed Nurse (LN) H approached the facility for her scheduled shift. LN H observed R1 swinging the nasal cannula tubing around and trying to put out the fire. LN H disconnected the tubing from the oxygen cylinder on the back of the wheelchair and turned off the oxygen flow. R1 sustained facial burns and later became hypoxic (insufficient oxygen), which required emergent treatment. The failure placed R1 in immediate jeopardy.

Findings included:

- R1's Electronic Medical Record (EMR), under the "Face Sheet" tab, recorded diagnoses of acute respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) with acute exacerbation (worsening of a disease or an increase in its symptoms), pneumonia (inflammation of the lungs), and dependence on supplemental oxygen.

R1's "Entry Minimum Data Set" (MDS) dated 12/08/23 documented R1 admitted to the facility.

R1's "Baseline Care Plan" initiated 12/08/23 lacked directives related to R1's smoking

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preference or interventions to address R1's ability to smoke safely.

R1's "Admission Nursing Observation" assessment dated 12/08/23 documented R1 was alert and oriented to person, place, time, and situation. The assessment inaccurately recorded R1 did not smoke.

R1's "Inter-Agency Transfer Order" dated 12/08/23 documented R1 required continuous oxygen at six LPM at rest and eight LPM with activity via nasal cannula with concentrator, portability, and/or conserving device.

R1's "Orders" in the EMR ordered oxygen per nasal cannula to maintain oxygen saturation (SpO2-the amount of oxygen in the bloodstream) greater than 90 percent (%). Document LPM every shift. Oxygen may be titrated or discontinued as tolerated by R1 while SpO2 maintained over 90 %.

The "Progress Note" dated 12/08/23 at 01:21 PM documented R1 arrived with no signs or symptoms of distress noted. R1 was on six LPM oxygen per nasal cannula continuously and might need to be increased to eight LPM per report from the hospital. The note recorded R1 stated he was unable to sign anything due to fine tremors in his hands.

The "Progress Note" dated 12/08/23 at 06:19 PM documented LN H arrived early and reported R1 was outside trying to smoke with his oxygen on and burned himself. LN H reported she disconnected R1's oxygen tubes and noted when R1 was brought in, R1 had soot all over his face.

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The "Progress Note" dated 12/08/23 at 06:35 PM documented LN G was notified by LH H at approximately 05:50 PM that R1 was outside smoking with his oxygen cannula on and six LPM of oxygen flowing. LN H saw flames and immediately shut off the oxygen tank. LN G went outside and observed R1 upright in his wheelchair with soot on his face, hands, and around his nose. LN G cleaned the soot off the R1's hands, nose, and face. R1 had redness to areas of his face, nose and cheeks, as well as singed hair on his mustache and eyebrows. R1 did not have any blisters or wounds observed at that time. Upon return to R1's room, R1's SpO2 was at 91% on six LPM per nasal cannula. LN J notified Consultant GG and awaited call back. R1's cigarettes and lighter were removed from R1's room and placed in the medication cart.

The "Progress Note" dated 12/08/23 at 08:50 PM documented R1 had thick mucus blocking his airway. R1 had an SPO2 of 85% despite supplemental oxygen flowing via nasal cannula at six LPM. The facility sent R1 to the emergency room at 09.04 PM.

The "Progress Note" dated 12/09/23 at 09:00 AM documented R1 admitted to the hospital burn unit.

CNA M's "Witness Statement" dated 12/11/23 documented CNA M entered R1's room and R1's daughter immediately told CNA M to make sure R1 got his smoke breaks. A few hours later, LN G told CNA M to take R1 outside to smoke. CNA M stated that with "everything going on," she did not really think about R1's oxygen. CNA M took R1 outside and then came back into the building to get meal trays.

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LN H's "Witness Statement" dated 12/11/23 documented LN H pulled up to the building around 05:40 PM and noted R1 outside in his wheelchair. As LN H walked towards R1, LN H saw R1 swinging his oxygen tubing trying to put out a fire. LN H quickly approached R1, disconnected the cannula tubing from the concentrator to stop the oxygen supply, then checked on R1. R1 had black soot around his face, cheeks, and nose. LN H established R1 was out of danger, then went and reported to the admission nurse and LN G. LN G and LN H brought R1 in from outside, cleaned the soot from all over his nose and cheeks, and then LN G took over cares.

On 12/13/23 at 12:00 PM Administrative Nurse D stated she expected staff to ask new admission (residents) if they smoke or not, and to assess if the newly admitted resident was safe to smoke or required supervision.

On 12/13/23 at 12:19 PM LN I stated she did not ask R1 about smoking. LN I further stated she reviewed the hospital paperwork and did not see any information related to a history of smoking or that R1 did smoke.

On 12/13/23 at 02:01 PM CNA M stated that R1's family member wanted to make sure R1 received his smoke breaks. CNA M further stated LN G asked CNA M to take R1 out for a smoke break. CNA M took R1 outside to smoke, asked what time R1 wanted to come back inside and the left R1 outside alone. CNA M revealed she forgot about R1's oxygen being on when she left R1 outside to smoke.

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The facility's "Smoking Policy" lacked a date documented residents could not carry smoking materials unless the patient has demonstrated safe smoking habits and practices determined by the assessment for residents who smoke. Residents may smoke in the designated smoking area without staff supervision if the resident has demonstrated safe smoking habits and practice determined by the assessment for residents who smoke.

The facility failed to ensure staff identified smoking related hazards and provided adequate care and supervision to avoid preventable smoking related accidents for admitting resident R1. A facility CNA brought R1 outside to smoke with is oxygen on per nasal canula, which caught on fire and caused facial burns to R1, who subsequently admitted to a burn unit. This failure placed R1 in immediate jeopardy.

The facility completed the following corrective actions by 12/11/23:

The smoking policy was updated, and the facility has changed to a non-smoking facility with smoking residents that were already admitted grandfathered in.
The two smoking residents had a safety smoking assessment completed on 12/09/23.
The Nurses have received training related to asking the residents about smoking and performing the smoking assessment even though the facility is no longer a smoking facility to assure safety.
The facility staff received training related to smoking safety on 12/11/23

The corrective actions were completed prior to

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F 689	Continued From page 7 the onsite survey therefore the citation was issued as past noncompliance at the scope and severity of "J."	F 689		