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D 000	Initial Comments The Adult Care Licensure Section conducted an annual, follow-up survey and complaint investigation from 04/29/26 to 05/01/26. The complaint investigation was initiated by the Lee County Department of Social Services on 04/06/26.	D 000		
D 113	10A NCAC 13F .0311 (d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall supply hot water to the kitchen, bathrooms, laundry, housekeeping closets, and soiled utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F and shall not exceed 116 degrees F. Notwithstanding the requirements of Rule .0301 of this Section, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure water temperatures were maintained between 100 to 116 degrees Fahrenheit (F) at fixtures accessible to residents as evidenced by 10 of 12 fixtures with water temperatures ranging from 117.6 degrees F to 124.3 degrees F. The findings are: Observation of the water temperatures in the facility 04/29/26 during the initial tour from 8:50am to 9:45am revealed:	D 113		

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-At 8:50am, the water temperature at the bathroom sink fixture in room 13 was 117.9 degrees F.
-At 8:58am, the water temperature at the shower room sink fixture was 122.7 degrees F.
-At 8:59am, the water temperature at the bathroom sink fixture in room 25 was 118.9 degrees Fahrenheit (F).
-At 9:09am, the water temperature at the bathroom sink fixture in room 15 was 121.9 degrees F.
-At 9:12am, the water temperature at the bathroom shower fixture in room 15 was 118.7 degrees F.
-At 9:12am, the water temperature at the bathroom sink fixture in room 6 was 122.3 degrees F.
-At 9:20am, the water temperature at the bathroom sink fixture in room 1 was 124.3 degrees F.
-At 9:33am, the water temperature at the sink fixture in bathtub room was 120.3 degrees F.
-At 9:42am, the water temperature at the sink fixture in the unlocked beauty shop room was 117.6 degrees F.
-At 9:44am, the water temperature at the hair shampoo bowl fixture in the unlocked beauty shop room was 120.7 degrees F.

Review of the facility's March 2026 water temperature logs revealed:
-On 03/13/26, the hot water temperature ranged from 118.3 degrees F to 118.4 degrees F at two fixtures labelled as "W-W Rm #". There were no specific room numbers, fixture type, or time of the water temperature check documented.
-On 03/13/26, the hot water temperature ranged from 118.2 degrees F to 118.9 degrees F at two fixtures labelled as "E-W Rm #". There were no specific room numbers, fixture type, or time of the

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water temperature check documented.
-On 03/13/26, the hot water temperature was 119.2 degrees F at the employee bath fixture.
-On 03/22/26, the hot water temperature ranged from 116.2 degrees F to 117.9 degrees F at two fixtures labelled as "W-W Rm #". There were no specific room numbers, fixture type, or time of the water temperature check documented.
-On 03/22/26, the hot water temperature ranged from 118.2 degrees F to 121.1 degrees F at two fixtures labelled as "E-W Rm #". There were no specific room numbers, fixture type, or time of the water temperature check documented.
-On 03/22/26, the hot water temperature was 118.9 degrees F at the employee bath fixture.
-On 03/28/26, the hot water temperature ranged from 118.7 degrees F to 119.2 degrees F at two fixtures labelled as "W-W Rm #". There were no specific room numbers, fixture type, or time of the water temperature check documented.
-On 03/28/26, the hot water temperature ranged from 118.2 degrees F to 118.1 degrees F at two fixtures labelled as "E-W Rm #". There were no specific room numbers, fixture type, or time of the water temperature check documented.
-On 03/28/26, the hot water temperature was 121.1 degrees F at the employee bath fixture.

Review of the facility's April 2026 water temperature logs revealed:
-On 04/15/26, the hot water temperature ranged from 117.7 degrees F to 118.2 degrees F at two fixtures labelled as "W-W Rm #". There were no specific room numbers, fixture type, or time of the water temperature check documented.
-On 04/25/26, the hot water temperature ranged from 117.8 degrees F to 118.2 degrees F at two fixtures labelled as "E-W Rm #". There were no specific room numbers, fixture type, or time of the water temperature check documented.

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D 113	Continued From page 3 Interview with a resident in room 15 on 04/29/26 at 4:25pm revealed: -He used the hot water in the bathroom sink. -The water temperature was not too hot. Interview with a housekeeper on 04/29/26 at 9:45am revealed: -She used the hot water for mopping. -She did not know how to describe the hot water temperature, but thought it felt "pretty normal, like your water at home, maybe a little bit more than warm". Interview with the Maintenance Director on 04/29/26 at 9:50am revealed: -He checked hot water temperatures at the facility. -The hot water temperatures ranged 117 degrees F to 118 degrees F on 04/25/26. -"E-W" meant employee bathroom fixture. -"W-W" meant resident room fixtures. -He had not had any complaints from residents or staff regarding hot water temperatures. -The hot water temperature on the thermostat on the hot water tank that supplied water to resident rooms was set at 120 degrees "right now". -If the thermostat on the hot water tank was set at 115 degrees F, the water temperature to the resident rooms could go down to 112 degrees F or 113 degrees F, and the hot water tank would have to heat up again. -He thought the recommended range for hot water was 115 degrees F to 118 degrees F. Second observations of the hot water temperatures in the facility 04/29/26 from 10:34am to 10:58am with the Maintenance Director after calibration of thermometers revealed:	D 113		

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D 113	Continued From page 4 -At 10:36am, the water temperature at the bathroom sink fixture in room 25 was 118.5 degrees Fahrenheit (F) with the surveyor's thermometer and 119.5 degrees F with the facility's thermometer. -At 10:40am, the water temperature at the bathroom sink fixture in room 15 was 121.6 degrees F with the surveyor's thermometer and 122.9 degrees F with the facility's thermometer. -At 10:43am, the water temperature at the bathroom shower fixture in room 15 was 119.4 degrees F with the surveyor's thermometer and 120.9 degrees F with the facility's thermometer. -At 10:47am, the water temperature at the sink fixture in bathtub room was 122.1 degrees F with the surveyor's thermometer and 123.4 degrees F with the facility's thermometer. -At 10:55am, the water temperature at the hair shampoo bowl fixture in the locked beauty shop room was 119.3 degrees F with the surveyor's thermometer and 119.7 degrees F with the facility's thermometer. -At 10:58am, the water temperature at the sink fixture in the locked beauty shop room was 122 degrees F with the surveyor's thermometer and 121.6 degrees F with the facility's thermometer. -At 11:07am, the water temperature at the shower room sink fixture was 126.9 degrees F with the facility's thermometer. -At 11:07am, the water temperature at the bathroom sink fixture in room 1 was 125.4 degrees F with the facility's thermometer. Observation of the hot water tank with the Maintenance Director on 04/29/26 at 11:04am revealed there were two hot water tanks in a locked room. Interview with the Maintenance Director on 04/29/26 at 11:04am revealed:	D 113		

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D 113	Continued From page 5 -The hot water tank on the left (closest to the wall) supplied hot water to the residents' rooms and the hot water tank on the right (closest to the door) supplied hot water to the kitchen. -The thermostat on the hot water tank that supplied hot water to the residents' rooms was set at 130 degrees F. -He had not checked the hot water tank temperature since March 2026. -The thermostats on the hot water tanks were reset in March 2026 by the gas company after some road maintenance was completed. -He would lower the thermostat on the hot water tank that supplied hot water to residents' rooms and monitor the hot water temperatures. Interview with the Administrator on 04/30/26 at 8:43am revealed: -She thought maintenance was supposed to check water temperatures every day and document the readings. -She thought hot water temperatures were not supposed to be over 120 degrees F. -She would be concerned that someone could burn themselves if the water temperatures were too hot. -She had not received any reports from residents or staff regarding the water temperatures being too hot. -She was not aware of any hot water temperatures obtained the Maintenance Director.	D 113		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no findings listed on the North Carolina	D 137		

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D 137	Continued From page 6 Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff B) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are: Review of Staff B's personnel record on 05/01/26 revealed: -Staff B was hired as a personal care aid (PCA) on 07/30/24. -There was a job description for Staff A dated 08/05/24. -There was documentation for a health care personnel registry (HCPR) check performed on 05/01/26. -There was no documentation for a HCPR check performed prior to or upon hire. Interview with Staff B on 04/29/26 at 2:05pm revealed she worked as a PCA at the facility. Interview with the Business Office Manager (BOM) on 05/01/26 at 10:30am revealed: She was responsible for obtaining the employee's HCPR checks. -She performed the HCPR checks before the hire date of new employees. -She performed the HCPR check for Staff B on 05/01/26. -Staff B had worked at the facility a few times and the most recent hire date was 07/30/24. -She thought the HCPR check for Staff B was missed upon the rehire on 07/30/24.	D 137		

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D 137	Continued From page 7 -She was not employed at the facility when Staff B was rehired. -She checked employee personnel records at least two times a week but had not checked Staff B's personnel record yet. -HCPR checks were supposed to be performed prior to hire. Interview with the facility Health and Wellness Director (HWD) on 05/01/26 at 11:20am revealed: -He did not know for sure who was responsible for performing HCPR checks. -He was responsible for hiring new staff. -He provided information to the BOM that was needed to conduct the HCPR checks for staff he planned to hire. Interview with the Administrator on 05/01/26 at 11:25am revealed: -There should be a HCPR check for Staff B. -Staff B was hired prior to her employment as the Administrator. -There should not be anybody working at the facility without a HCPR check. -She was not aware of a facility process for checking personnel files after hire to ensure appropriate documentation was in place, such as HCPR checks.	D 137		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.	D 270		

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This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 4 sampled residents (#4) was supervised resulting in the resident smoking a cigarette inside of his bedroom with an oxygen concentrator which led to a fire.

The findings are:

Review of facility smoking policy dated 2025 revealed:
-Smoking was prohibited in all areas except the designated smoking area.
-If a resident does not abide by the smoking policy the plan of care may be revised to include additional safety measures.
-Smoking materials of residents requiring supervision with smoking will be maintained by nursing staff.

Review of Resident #4's current FL2 dated 04/06/26 revealed:
-Diagnoses included chronic obstructive pulmonary disease (COPD), coronary artery disease, hypertension, acute kidney injury and heart failure.
-He was semi-ambulatory with a wheelchair.
-There was no information on orientation.
-Level of care was assisted living.

Review of Resident #4's Resident Register

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revealed:
-The date of admission was 01/05/26.
-The resident was not a smoker.

Review of Resident #4's care plan dated 03/30/26 revealed Resident #4 required limited assistance with ambulation, bathing, dressing, and grooming, and supervision with eating and toileting.

Review of Resident #4's hospice notes dated 03/18/26 revealed oxygen gas for inhalation 2-4 Liters via nasal cannula continuous for shortness of breath.

Review of Resident #4's Accident/Incident Report dated 03/27/26 revealed:
-On 03/27/26 at 7:31am Resident #4 had an incident reported as smoking that caused a small fire.
-Resident #4 lit a cigarette in his room while having on his oxygen tube.
-The ashes appeared to have fallen on the nasal cannula tube which caused a fire to spark.
-Fire fell on the floor which caused a lot of smoke to fill the entire room and the hallway.
-The resident was transferred to the hospital by emergency medical services (EMS).
-The recommended steps to prevent recurrence was Resident #4 could possibly be given a 30 day discharge notice due to recurring behavior.

Review of Resident #4's hospital discharge instructions dated 03/31/26 revealed:
-Resident #4 was admitted to the hospital on 03/27/26.
-The reason for the visit was Resident #4 fell asleep smoking a cigarette, woke up to fire in room, and was having trouble breathing.
-Resident #4's diagnosis included COPD exacerbation, smoke inhalation, and inhalation

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D 270	Continued From page 10 injury. Review of Resident #4's smoking safety screen dated 04/06/26 revealed: -The resident did not have cognitive loss. -The resident was safe to smoke without supervision. -Cigarettes and lighters were locked up for safe storage. -The resident needed more encouragement not to smoke due to use of oxygen. Review of Resident #4's Accident/Incident Report dated 04/06/26 revealed: -On 04/06/26 at 11:20am Resident #4 had an incident reported as out of breath. -Resident #4 requested to be sent to the emergency room for breathing. -The primary care provider (PCP) and hospice nurse agreed with sending the resident out to the hospital. -The resident was transferred to the hospital by EMS. Review of Resident #4's facility progress notes by the Health and Wellness Director (HWD) dated 01/17/26 revealed: -Resident #4 was redirected for smoking in his room. -Resident #4 claimed he did not realize where he was. -Resident #4 was encouraged not to smoke epecially with his oxygen. Interview with Resident #4 on 04/30/26 at 10:00am revealed: -He remembered waking up in his walker confused and thought that he was outside and lit a cigarette on 03/27/26. -When he realized he was in his bedroom and his	D 270		

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nasal cannula was in his nose he attempted to flick the cigarette so the flame would go out.
-The ash from the cigarette fell on the tube attached to his oxygen concentrator.
-His nasal cannula caught on fire near where it attached to the concentrator.
-He pulled the tube out of the concentrator so that it would not catch on fire.
-Part of his carpet on his floor caught on fire.
-Staff members came in and evacuated him to the parking lot of the facility.
-EMS took him to the hospital.
-He had smoked a cigarette in his room one other time because he was confused.
-He normally smoked in the designated smoking area and left his O2 concentrator in his bedroom.
-He kept his cigarettes and his lighter on his rollator.
-He was discharged from the facility not long after he returned from the hospital because his breathing had gotten worse.

Interview with a housekeeper on 04/30/26 at 11:05am revealed:
-She began her shift as housekeeper at 7:00am on 03/27/26.
-She was on the opposite side of the building when the fire alarm began to go off.
-She saw smoke in the hallway near Resident #4's bedroom.
-She began to help evacuate residents outside of the building.
-She assisted with getting Resident #4 out of the building.
-Resident #4 did not have any visible injuries or burns.
-She was not aware of Resident #4 ever smoking in his bedroom.

Interview with a personal care aide (PCA) on

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D 270	Continued From page 12 04/29/26 at 2:10pm revealed: -She worked as a PCA on first shift on 03/27/26, which was 7:00am-3:00pm. -She was in the hallway when the fire alarm sounded. -She went to Resident #4's bedroom and the carpet was on fire. -The fire on the floor was approximately the size of a facility resident folder (about 8.5 inches by 14 inches). -Resident #4 had an O2 concentrator and the nasal canula that attached to his nose was burned. -The O2 concentrator was running. -The nasal canula attached to Resident #4's face was intact. -The tubing near the O2 concentrator was burned. -There were no burn marks on the resident or on his clothes. -Resident #4 kept his cigarettes and his lighter in his bedroom. -She had never seen Resident #4 smoke a cigarette in his room. -Resident #4 usually smoked in the designated smoking area. -Resident #4 got continuous O2 via his nasal canula. -Resident #4 was independent and drove himself to the store for cigarettes and other items. -Resident #4 did have moments when he was forgetful. Interview with a medication aide (MA) on 04/29/26 at 2:25pm revealed: -She worked as a PCA on first shift on 03/27/26, which was 7:00am-3:00pm. -She heard the fire alarm begin to alert and she realized it was coming from Resident #4's bedroom.	D 270		

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-When she entered Resident #4's bedroom she observed a small fire on the carpet.
-The fire was near Resident #4's feet and it was about 12 inches high.
-She observed fire on Resident #4's nasal canula.
-The O2 tube was not connected to the oxygen concentrator.
-She went to the nursing station which is two doors away from Resident #4's bedroom and retrieved the fire extinguisher.
-Resident #4 was pouring soda onto the fire in an attempt to put the fire out and she began to do the same.
-When she realized the fire was not going out she began to evacuate Resident #4 from the bedroom.
-The fire truck and EMS arrived at the facility shortly after they began evacuating residents.
-She had never observed Resident #4 smoking cigarettes in his room.
-Resident #4 smoked approximately four to five times each day during her shift.
-Resident #4 was very independent and drove himself to the store and to doctors appointments.
-Resident #4 needed some assistance with getting dressed and he used a rollator for mobility.
-He stayed in the facility about two or three days after his return from the hospital and had to go back to the hospital due to his problems breathing.

Interview with the Maintenance Director on 05/01/26 at 10:30am revealed:
-He taught each new staff members about fire safety, fire doors, how to use fire extinguishers, and the sprinkler system during orientation.
-He did in-service training for staff members on fire safety a minimum of two times each month.
-All staff members were taught how to properly

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use a fire extinguisher and the location of the fire extinguishers throughout the facility.

Interview with a Resident Care Coordinator (RCC) on 04/30/26 at 11:10am revealed:
-On 03/27/26 she arrived at the facility after the incident had occurred.
-Resident #4 had two or three occurrences when he was observed to have smoked cigarettes in his bedroom.
-Resident #4 was having increased confused in the two weeks leading up to the incident on 03/27/26.
-If a resident was believed to be smoking cigarettes in their bedroom the facility did a weekly smoking report and checked for any signs of smoking in the facility.
-There was not a weekly smoking report completed on Resident #4.
-If there were signs of a resident smoking in their bedroom staff informed the resident that they were not allowed to smoke in the facility and reminded them of the designated smoking area.
-The HWD was alerted about resident smoking in the facility in order to take next steps to prevent this behavior.
-The facility staff should have taken Resident #4's cigarettes and locked them on the medication cart in order to monitor his smoking after he was caught smoking in his room the first time.

Interview with the HWD on 04/30/26 at 11:30am revealed:
-On 03/27/26 he arrived at the facility after the incident had occurred.
-When he arrived on the scene the fire department and EMS were there and the residents were being evacuated.
-Resident #4 was independent with his activities of daily living (ADLs).

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-Resident #4 had moments of confusion when his oxygen was not being used properly.
-Resident #4 was caught smoking in his bedroom one time prior to the incident on 03/27/26.
-Resident #4 was encouraged to smoke only in the designated smoking area.
-The facility was supposed to inform the care team which included: the PCP, mental health, and hospice about Resident #4 being caught smoking in his bedroom.
-He was not the HWD when Resident #4 was caught smoking on 01/17/26.
-The facility staff asked Resident #4 to give them his cigarettes and lighters to lock onto the medication cart in order to monitor his smoking.
-The facility staff did checks on Resident #4's room regularly, looking for signs he had been smoking.
-He believed Resident #4 was getting enough supervision and that there was nothing that could have been done to prevent the incident on 03/27/26 from occuring.

Interview with the Administrator on 04/30/26 at 11:50am revealed:
-Resident #4 did not have a smoking safety screen prior to the incudent on 03/27/26 because he reported he was not a smoker when he was admitted to the facility.
-The facility should have completed a smoking safety screen for Resident #4 when they realized he smoked cigarettes.
-She was not at the facility when the incident occurred on 03/27/26.
-She received a telephone call from the HWD and was told that Resident #4 started a fire in his bedroom and was at the hospital.
-The facility policy stated that residents must smoke in the designated smoking area and no smoking was ever allowed in the building.

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-A MA once told her that Resident #4 was attempting to smoke a cigarette in his room.
-She talked to Resident #4 about the importance of smoking in the designated area and the dangers of smoking near his O2 concentrator.
-When a resident was caught smoking in the facility they took the residents' cigarettes and lighter and placed them on the medication cart so that facility staff could monitor their smoking and ensure they were smoking in the designated smoking area.
-Resident #4 did not have disciplinary actions taken after smoking in the facility.
-Resident #4 should have had his cigarettes taken and locked on the medication cart.
-She did not know why no disciplinary actions were taken with Resident #4 when he was first caught smoking in his bedroom.
-She had concerns because Resident #4 had an O2 concentrator in his bedroom and smoking in his room could have caused a disaster.
-Resident #4 was not being monitored properly and did not have the supervision he needed as a smoker with O2.

Interview with a Hospice Nurse on 04/30/26 at 10:55am revealed:
-Resident #4 had been admitted to Hospice due to heart failure.
-Resident #4 was alert and oriented to person, place, time, and situation.
-Hospice was not aware that Resident #4 had been caught smoking cigarettes in his room with his O2 prior to 03/27/26.
-If hospice would have been made aware they would have advised the facility to lock up his cigarettes and monitor his smoking.
-She was concerned about the lack of supervision because the O2 tank could have exploded and damage could have been much more severe.

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-After returning to the facility from the hospital on 03/31/26 Resident #4's had worsening COPD.
-On 04/06/26 Resident #4 had to return to the hospital for more aggressive treatment related to respiratory issues.

Interview with Resident #4's primary care provider (PCP) on 04/30/26 at 12:10pm revealed:
-Resident #4 had increased confusion the last few weeks he was at the facility.
-He had a couple falls during that time and had to go out to the hospital.
-She was not made aware that Resident #4 had been smoking in his room with his O2 concentrator prior to the incident on 03/27/26.
-She would have informed the facility staff to re-educate Resident #4 on the importance of not smoking near his O2 concentrator, and to increase supervision.
-Resident #4 inhaling smoke from the fire on 03/27/26 could have led to his worsening COPD.
-Any contact with smoke would have caused inflammation and irritation of the throat and tongue and damage to tissue in the throat and mouth.
-She was concerned because the O2 concentrator was highly flammable and could have exploded and put staff and residents at risk.
-She saw Resident #4 for a follow up after he was released from the hospital on 04/06/26.
-Resident #4 had a fall and it took 3 staff to get him off of the floor.
-She informed the facility that he needed a higher level of care.

Attempted telephone interview with county fire inspector on 04/30/26 at 2:26pm was unsuccessful.

Attempted telephone interview with county fire

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D 270	Continued From page 18 chief on 05/01/26 at 9:55am was unsuccessful. The facility failed to ensure a resident (#4) who had diagnosis of chronic obstructive pulmonary disease was properly supervised. Resident #4 had a prior occurrence of smoking cigarettes in his room with his O2 concentrator. Resident #4 was observed to have increased confusion in the weeks leading up to the incident that occurred on 03/27/26 in which Resident #4 became confused thinking he was outside and smoked a cigarette in his bedroom while his O2 tank was delivering oxygen via nasal cannula starting a fire. The facility did not take steps to ensure Resident #4 did not smoke in his bedroom. This failure resulted in neglect of the resident and constitutes a Type A2 Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on April 6, 2026. CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED May 31, 2026.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure referral and follow-up to meet the acute health care needs of 1 of 4 sampled residents (#4) related to notifying a resident's primary care provider (PCP) of the	D 273		

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resident smoking in his bedroom with an oxygen (O2) concentrator in use.

The findings are:

Review of Resident #4's current FL2 dated 04/06/26 revealed:
-Diagnoses included chronic obstructive pulmonary disease, coronary artery disease, hypertension, acute kidney injury and heart failure.
-He was semi-ambulatory with a wheelchair.
-There was no information on orientation.
-Level of care was assisted living.

Review of Resident #4's Resident Register revealed the date of admission was 01/05/26.

Review of Resident #4's care plan dated 03/30/26 revealed Resident #4 required limited assistance with ambulation, bathing, dressing, and grooming, and supervision with eating and toileting.

Review of Resident #4's hospice orders dated 03/18/26 revealed there was an order for oxygen gas for inhalation 2-4 Liters via nasal cannula continuous for shortness of breath.

Review of Resident #4's Accident/Incident Report dated 03/27/26 revealed:
-On 03/27/26 at 7:31am Resident #4 had an incident reported as smoking caused a small fire.
-Resident #4 lit a cigarette in his room while having on his oxygen tube.
-The ashes appeared to have fallen on the nasal cannula tube which caused a fire to spark.
-Fire fell on the floor which caused a lot of smoke to fill the entire room and the hallway.
-Resident was transferred to the hospital by emergency medical services (EMS).

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D 273	Continued From page 20 -The recommended steps to prevent recurrence was Resident #4 could possibly be given a 30 day notice due to recurring behavior. Interview with Resident #4 on 04/30/25 at 10:00am revealed: -He remembered waking up in his walker confused and thought that he was outside and lit a cigarette. -When he realized he was in his bedroom and his nasal cannula in his nose he attempted to flick the cigarette so the flame would go out. -The ash from the cigarette fell on the tube attached to his oxygen concentrator. -His nasal cannula caught on fire near where it attached to the concentrator. -He pulled the tube out of the concentrator so that it would not catch on fire. -Part of the carpet on his floor caught on fire. -Staff members came in and evacuated him to the parking lot of the facility. -EMS took him to the hospital. -He had smoked a cigarette in his room one other time because he was confused. -Staff had observed him smoking a cigarette in his room before the incident where he caused a fire in his bedroom. -He normally smoked in the designated smoking area and left his 02 concentrator in his bedroom. -The facility staff did not lock his cigarettes on the medication cart. -He kept his cigarettes and his lighter on his rollator. Interview's with the Resident Care Coordinator (RCC) on 04/30/26 at 11:10am and on 05/01/26 at 9:25am revealed: -Resident #4 had two or three occurrences when he was observed to have smoked cigarettes in his bedroom.	D 273		

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-She did not know if the primary care provider (PCP) was made aware that Resident #4 had been observed smoking in his bedroom on multiple occasions.
-There was no documentation that the PCP had been made aware of Resident #4 smoking in his bedroom prior to the incident where he started the fire on 03/27/26.
-The RCC and Health and Wellness Director (HWD) were responsible for ensuring the PCP was notified about Resident #4 smoking in his bedroom with his O2 concentrator in use.

Interview's with the HWD on 04/30/26 at 11:30am revealed: and again on 05/01/26 at 11:10am revealed:
-Resident #4 was caught smoking in his bedroom one time prior to the incident on 03/27/26.
-The facility was supposed to inform the care team which included: the PCP, mental health provider (MHP), and hospice about Resident #4 smoking in his bedroom.
-The PCP, MHP, and the hospice nurse were not notified that Resident #4 was observed smoking cigarettes in his bedroom with his O2 concentrator in use.
-The medication aides (MAs) were responsible for notifying the PCP, RCC, HWD and Administrator about health care issues with residents.

Interview's with the Administrator on 04/30/26 at 11:50am and on 05/01/26 at 11:30am revealed:
-An MA once told her that Resident #4 was attempting to smoke a cigarette in his room.
-She talked to Resident #4 about the importance of smoking in the designated area and the dangers of smoking near his O2 concentrator.
-The MAs were responsible for notifying the PCP that Resident #4 had been observed smoking

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cigarettes in his bedroom with his O2 concentrator in use.
-The RCC and HWD should have ensured that the PCP was notified that Resident #4 was smoking in his room.
-She expected the PCP to be notified about incidents that could have an impact on the resident's health.

Telephone interview with Resident #4's Hospice Nurse on 04/30/26 at 10:55am revealed:
-Hospice was not aware that Resident #4 had been smoking cigarettes in his room with his O2 prior to 03/27/26.
-If hospice would have been made aware they would have advised the facility to lock up his cigarettes and monitor his smoking.

Telephone interview with Resident #4's PCP on 04/30/26 at 12:10pm revealed:
-She was not made aware that Resident #4 had been smoking in his room with his O2 concentrator prior to the incident on 03/27/26.
-She would have informed the facility staff to re-educate Resident #4 on the importance of not smoking near his O2 concentrator, and to increase his supervision.