Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

Administrator
Wabasso Restorative Care Center
660 Maple Street
Wabasso, MN 56293

RE: CCN: 245400
Cycle Start Date: September 24, 2024

Dear Administrator:

On October 30, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 5, 2024

Administrator
Wabasso Restorative Care Center
660 Maple Street
Wabasso, MN 56293

Re: Reinspection Results
Event ID: ROSM12

Dear Administrator:

On October 30, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 24, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 3, 2024

Administrator
Wabasso Restorative Care Center
660 Maple Street
Wabasso, MN 56293

RE: CCN: 245400
Cycle Start Date: September 24, 2024

Dear Administrator:

On September 24, 2024, a survey was completed at your facility by the Minnesota Departments of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

Nicole Osterloh, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by December 24, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 24, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates

specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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October 3, 2024

Administrator
Wabasso Restorative Care Center
660 Maple Street
Wabasso, MN 56293

Re: State Nursing Home Licensing Orders
Event ID: ROSM11

Dear Administrator:

The above facility was surveyed on September 23, 2024 through September 24, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Nicole Osterloh, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245400	A. BUILDING _____ B. WING _____	C 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WABASSO RESTORATIVE CARE CENTER	660 MAPLE STREET WABASSO, MN 56293

(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 On 9/23/24 and 9/24/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed H54008040C (MN00106314), H54008041C (MN00106326), H54008761C (MN00106848), and H54008900C (MN00106934) with a deficiency cited at F600 and F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		10/24/24

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

Electronically Signed | 10/15/2024

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.

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F 600	Continued From page 1 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure residents were free and protected from physical abuse for 2 of 3 residents (R2 and R3) reviewed for resident-to-resident abuse when on two separate occasions R1 physically abused R2 and R3. Additionally failed to implement protection measures according to R1's care plan to prevent re-current physical abuse. Findings Include: R1's quarterly Minimum Data Set (MDS) dated 8/16/24, indicated R1 had moderate cognitive impairment, did not have sign/symptoms of delirium, and did not have behaviors. The MDS further indicated R1 was independent with walking, toileting, transferring, and personal cares with no upper or lower body impairments. Diagnoses included anemia, diabetes, depression, histrionic personality disorder (a mental health condition characterized by overwhelming desire to be noticed and dramatic behavior), nicotine dependence, and mild cognitive impairment. R1's care plan last updated 6/7/24, indicated R1 was at risk for abuse due to vulnerable adult status. Interventions included to anticipate and meet needs as able and not to have me near others who disturb me. The care plan also identified R1 had a potential to be verbally	F 600	Plan of Correction Elements for F600 1. R1 will be monitored and kept separated from other residents, ensuring constant supervision in high-risk areas, particularly the smoking area. R1 was discharged at the request of their guardian on September 28th. 2. All residents will have their care plans reviewed to identify those at risk of resident-to-resident abuse. Staff will receive training on recognizing signs of potential abuse and the importance of implementing individualized care plans to ensure the safety of all residents. 3. Mandatory training by DON, social services, or designee on recognizing and preventing resident-to-resident abuse will be conducted for all staff, including education on de-escalation techniques and adherence to care plans. Facility policies on abuse prevention and response will be reviewed and updated as needed, to ensure compliance with regulatory standards. 4. The facility will present findings and corrective actions to the QAPI committee for ongoing review. Audits of care plans, incident reports, and staff adherence to	

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F 600	Continued From page 2 aggressive, yelling, and had an actual physical altercation with another resident. R1's Social Service Note dated 8/29/24 at 5:27 p.m., identified R1 was told she was not able to smoke anymore due to doctor's orders. R1 became verbally and physically upset. R1's daughter and guardian were notified R1 was to stop smoking due to safety reasons and R1's cigarettes were removed from her room. R1's Nursing Note dated 8/31/24 at 5:47 p.m., indicated residents reported R1 hit R3 in the ankle three times with a rock. R1 admitted to hitting R3 with the rock because R3 would not allow R1 to sit next to her. Staff notified the sheriff's department and R1 was transported to the emergency department (ED) for evaluation. Further indicated, prior to this incident around 12:00 p.m., a resident had reported to the nurse that R1 had a rock. R1 told the nurse she "wanted to us [use] the rock to hurt someone if she needed to but also said that she wanted to decorate it. The nurse took the rock from R1. R1's Nursing Note dated 8/31/24 at 11:00 p.m., indicated R1 returned from the ED with new medication orders for and antibiotic for cystitis and Remeron at bedtime for aggressive behaviors. Further stated R1 will be alone in her room for the safety of others and placed on 15-minute checks. R1's care plan was revised on 9/1/24 to include R1 needed 1:1 staff supervision at all times when resident was outside in the smoking area and 15-minute checks were to be completed until a new safety plan was established/evaluated as needed. Staff were also to remove any objects	F 600	training will be conducted once per week x 3 weeks, once per month x 1 month, to monitor effectiveness and compliance.	

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F 600	Continued From page 3 that could potentially cause resident injury or cause resident to injure others with her personal belongings. Review of the facility reported incident dated 8/31/24, indicated R1 hit R3 on the ankle with a rock while in the designated smoking area. R3's Quarterly Minimum Data Set (MDS) dated 9/7/24, indicated R3 had severe cognitive impairment, used a walker independently, and had diagnoses that included nicotine dependence and anxiety. Facility internal investigation submitted the State Agency (SA) identified R1 was put on 15-minute checks, moved closer to the nursing station, and removed any rocks bigger than a fist from the rock garden in the smoking area. R1's Nursing Noted dated 9/1/24 at 11:34 a.m., indicated the nurse was informed by other residents in the smoking area that R1 hit R2 in the face while out in the outside smoking area. Staff removed R1 from the smoking area and was placed in the facility's lobby area but due to R1's crying, agitation, and disruption staff took her to her room with 1:1 supervision until R1 transferred to the ED. R1 was noted to have a bloody nose and stated that R2 had also hit her in the nose. Review of the facility reported incident dated 9/1/24, indicated R1 punched R2 in the face during an altercation in the designated smoking area. R2 then punched R1 in the face as a response resulting in R1 having a bloody nose. The facility also identified staff were to supervise all residents during designated smoking times. R2's significant change MDS indicated R2 did not have cognitive impairment, required the use of a wheelchair, had range of motion impairment to	F 600		

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F 600	Continued From page 4 one lower extremity, and had diagnoses of nicotine dependence and anxiety disorder. The facility internal investigation submitted to the SA identified R1 was sent to the hospital for evaluation and denied hitting anyone. R1 was moved to a different room and supervised during smoking. In addition, an all-resident meeting was held, and resident's rights reviewed. R1's Behavior Charting dated 9/2/24 at 8:36 a.m., identified R1 went to another resident's room and took cigarettes. R1 returned to room and started smoking the cigarettes. During observation and interview on 9/24/24 at 11:55 a.m., R1 was sitting on the bed with a pack of cigarettes and a lighter sitting next to her on the bed. R1 stated a friend gave them to her. R1 admitted to going outside to smoke about 4-5 times a day and did not have staff with her when she smokes. R1 denied knowing that she was not to smoke and denied any difficulties with any of the other residents while out in the smoking area. During an observation on 9/24/24 at 1:17 p.m. R1 wheeled independently outside to the designated smoking area, R3 immediately came into the facility from the smoking area. R1 was observed sitting in her wheelchair on the sidewalk by the rock garden, lighting, and smoking two cigarettes with no observation of staff supervision. Five other residents were outside smoking in the same area. R1 re-entered the facility at 1:36 p.m. During an interview on 9/23/24 at 2 p.m., R2 described R1 punching her in the nose. R2 indicated the facility took R1's cigarettes away so R1 tries to beg or steal other resident's cigarettes.	F 600		

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F 600	Continued From page 5 R2 further explained that on 9/1/24, she was putting her cigarette butt into the disposal receptacle when R1 tried to take the butt out of the receptacle, R2 attempted to put an ice cube in it and R1 punched her in the face. Then out of reflex, R2 punched R1 in the face. R2 indicated as a result she experienced a headache for a couple of days. R2 denied any staff supervision while R1 was smoking. During an interview on 9/23/24 at 1:35 p.m., R3 shared an incident that occurred on 8/31/24, when R1 and R3 were in the outside smoking area and R1 "took a big rock and smashed my ankle three times". Further indicated staff were not present at the time of the incident and the facility staff continued to allow R1 go out to the smoking area 3-4 times a day without supervision. R3 indicated the facility took away everyone's smoking privileges because of R1's behavior by limiting the times they could smoke. R3 continued to explain she feared R1 and after the incident with the rock, will come back in the building as soon as R1 comes outside to the smoking area. R3 indicated there were about 20 residents that went out regularly to smoke and no one wanted to be near R1 because of her unpredictable anger. R3 indicated she felt the facility did not do anything to correct R1's behavior and had observed R1 grabbing rocks out of the rock garden in the smoking area the previous day (9/22/24). R3 further clarified R1 was not supervised by staff while smoking and picking up the rocks. During an interview on 9/23/24 at 3:30 p.m., R4 indicated he felt safe in the smoking area unless R1 was outside. R4 further indicated R1 "is a ticking timebomb". R4 explained R1 did not	F 600		

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F 600	Continued From page 6 always have staff supervision outside, would try to steal other resident's cigarettes and lighters, and had unpredictable anger outbursts. R4 identified R1 hit R2 with a rock and the next day hit R3 in the face because she would not give R1 a cigarette. During an interview on 9/23/24 at 3:35 p.m., R5 indicated R1 did not have staff supervision when she smoked outside, and he did not feel safe when R1 was outside. R5 did not elaborate any further. During an interview on 9/23/24 at 3:49 p.m., R6 indicated R1 was a danger to herself and others because "we never know when she is going to explode and start threatening us". R6 further indicated staff do not supervise R1 while smoking outside. During an interview on 9/24/24 at 2:54 p.m., R7 indicated he recently discharged from the facility but, witnessed the incident regarding R1 and R3 on 8/31/24. R7 identified R1 was outside smoking when the director of nursing (DON) took cigarettes away from R1. R1 became upset and started hitting the DON so the DON took the cigarettes and went back into the facility. R1 was upset and started backing her wheelchair between R7 and R3 but there was not enough room and R1 keep pushing back and running over their feet. R3 then put her foot up on the wheel of the wheelchair to prevent R1 from rolling back when R1 took a "fist sized rock out of her wheelchair and hit R3 ankle three times". An unidentified resident opened the door to hell at staff for help. R7 stated staff responded and R1 "threw herself to the ground and started banging her head on the cement".	F 600		

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WABASSO RESTORATIVE CARE CENTER	660 MAPLE STREET WABASSO, MN 56293

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F 600	Continued From page 7 During an interview on 9/23/24 at 2:50 p.m., nursing assistant (NA)-A indicated did not witness either incident, but it was reported to her that R1 hit R3 with a rock and then hit R2 and busted her glasses the next day. Further indicated she thought R1 had a "motivated plan, she [R1] is mean". NA-A further identified there were about 25 residents who smoke outside in the designated smoking area, but many will not go out there when R1 is there smoking. The facility set up a staff supervised smoking schedule after the incidents but that caused more arguments among the residents, so it was discontinued. NA-A further explained that R1 was observed falling asleep with a lit cigarette and ashes would drop on her clothes so R1 was supposed to wear a smoking apron but refused. NA-A identified the new plan was to check on R1 "every 5 minutes or so but she is quick, and we do not always know she is out there [smoking area]". During an interview on 9/24/24 at 11:22 a.m., NA-B indicated R1 did go outside to smoke independently but after the first incident, the facility started 1:1's but R1 was quick and got outside without staff knowing. Further identified that R1 continued to smoke outside without supervision and stated, "nobody said anything to me, so I have not been physically watching her smoke". NA-B indicated R1 hits and punches staff and other residents and the behaviors "were getting worse". During an interview on 9/24/24 at 12:06 p.m., NA-C stated if R1 goes outside to smoke, "we are supposed to check on her every so often to make sure she is safe and that everyone else around her is ok having her (R1) around". NA-C further	F 600		

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	245400	A. BUILDING _____ B. WING _____	C 09/24/2024

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F 600	Continued From page 8 indicated there was not a certain time limit to check on her, just every so often so it depended how busy the staff were. During an interview on 9/24/24 at 1:06 p.m., licensed practical nurse (LPN)-A stated, R1 "had her own cigarettes and staff tried to catch her when she went outside to smoke and check on her once in a while". LPN-A indicated R1 did not have 15-minute safety checks and did not know where the safety checks would be documented. During an interview on 9/23/24 at 3:04 p.m., registered nurse (RN)-A indicated the facility had tried to take R1's cigarettes away but she keeps getting them. Further identified R1 is not safe to smoke independently and they "try to have someone with her but that is not always possible". During an interview on 9/23/24 at 4:00 p.m., Social Service Designee (SSD) indicated R1's behaviors all surround smoking and the doctor had ordered R1 not to smoke because of R1's health and safety. The SSD further identified R1 should not have a lighter or cigarettes, but the facility cannot control what gets brought into the building. R1 has been noted to smoke in the building at times. Further indicated the facility investigation identified R1 did hit R2 with a rock and punched R3 in the face "with full intent". SSD further explained after the incident on 9/1/24, the facility implemented designated smoking times for all residents so staff could supervise all of them but lifted that restriction on the Friday after the incident (9/6/24). SSD indicated R1 could go outside to the smoking area to smoke without supervision but had to be monitored by staff. SSD identified she did not know how often the staff were monitoring R1	F 600		

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F 600	Continued From page 9 smoking. During an interview on 9/24/24 at 9:14 a.m., R1's primary medical doctor (MD) indicated he did not recall writing an order that R1 could not smoke but was concerned more about her safety risk for smoking. R1's MD further indicated R1 is a danger to the other residents and herself and staff should always be supervising R1 during smoking. During an interview on 9/24/24 at 11:55 a.m., the DON indicated she became aware of the incident on 8/31/24 when the residents were yelling for help in the designated smoking area. Further explained R1 had a "huge rock with sharp edges" in her hand and had hit R3 in the ankle three times. Further indicated R1's behaviors "ebb and flow" and they are "at a loss at what to do". R1 was noted to have smaller rocks under her wheelchair cushion that were provided to law enforcement when they arrived. The DON further indicated R1 was medicated with an antianxiety medication and transported to the ED for evaluation then upon R1's return, staff did 15-minute checks on R1 but was not sure if R1 had more cigarettes or a lighter in her possession. The DON further indicated staff are supposed to physically be with R1 when outside smoking, but staff cannot always catch R1 when she goes out to smoke. The facility's undated policy, Residents Right to Freedom from Abuse, Neglect, and Exploitation Policy and Procedure indicates the facility's residents have the right to be free from abuse, neglect, misappropriation of their property, and exploitation as defined in the policy. Staff shall monitor for any behaviors that may provoke a	F 600		

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F 600	Continued From page 10 reaction by residents or others, which include, but are not limited to , verbally aggressive behavior, such as screaming, cursing, bossing around/demanding, insulting to race or ethnic group, intimidating; Physically aggressive behavior such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, throwing objects; rummaging through others properties and wandering into other's rooms/spaces. The policy further identifies the abuse, the facility will take all appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately: the facility will increase enforcement action, including but not limited to: "Taking steps to prevention further potential abuse. "Conducting a thorough investigation of the alleged violation "Taking appropriate corrective action "Revise the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse.	F 600		
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 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		10/24/24

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F 689	Continued From page 11 Based on observation, interview, and document review the facility failed to implement and provide adequate supervision and safety interventions for 1 of 3 residents (R1) reviewed for smoking. Findings include R1's quarterly Minimum Data Set (MDS) dated 8/16/24, indicated R1 had moderate cognitive impairment, did not have sign/symptoms of delirium, and did not have behaviors. The MDS further indicated R1 was independent with walking, toileting, transferring, and personal cares with no upper or lower body impairments. Diagnoses included anemia, diabetes, depression, histrionic personality disorder (a mental health condition characterized by overwhelming desire to be noticed and dramatic behavior), nicotine dependence, and mild cognitive impairment. R1's care plan last updated 8/29/24, indicated R1 had been deemed unsafe to smoke by her physician. The goal was that R1 will not smoke. The interventions were to review smoking policy as needed and with any changes, R1 cannot smoke unsupervised and independently, and notify charge nurse immediately if it is suspected R1 has violated facility smoking policy. The care plan also identified R1 had a potential to be verbally aggressive, yelling, and had an actual physical altercation with another resident. The interventions updated on 9/1/24, identified R1 needed 1:1 staff supervision always when resident was outside in the smoking area. R1's Smoking Review dated 8/16/24, indicated R1 smoked 3-4 times a day and had a history of smoking related incidents such as burning	F 689	Plan of Correction Elements for F689 1. R1 received staff supervision for safety while in the smoking area to ensure safety and prevent unsafe behaviors. R1 was discharged at the request of their guardian on September 28th. 2. A comprehensive review of care plans for all residents will be conducted to identify those at-risk regarding smoking behaviors. Staff will be trained to recognize risks and implement appropriate safety measures for all residents. 3. DON, Social Services, or designee will train staff on updated policies and procedures, if applicable, related to smoking supervision and safety. 5. The QAPI committee will receive regular reports on the implementation of corrective actions, supervision logs, and incident reports. Audits of care plans, incident reports, and staff adherence to training will be conducted once per week x 3 weeks, once per month x 1 month, to monitor effectiveness and compliance.	

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F 689	Continued From page 12 clothing, smoking in bed, and dropping ashes on self. The recommendation was R1 not safe to smoke and provider notified. R1's Nursing Note on 8/28/24 at 1:44 p.m., indicated R1 was informed of the safety concerns observed while smoking and not passing the smoking assessment. Offered nicotine patches/gun [gum] but refused. Will continue to monitor/educate on safe smoking. R1's Physician's Note dated 8/28/24 at 10:42 p.m., identified R1 was observed falling asleep while walking with a cigarette in her mouth. Plan was to notify R1's guardian of the need to revoke smoking privileges due to safety concerns and of the possible need for new placement as R1 was likely to refuse cessation of smoking privileges. R1's Social Service Note dated 8/29/24 at 5:27 p.m., identified R1 was told she was not able to smoke anymore due to doctor's orders. R1 became verbally and physically upset. R1's daughter and guardian were notified R1 was to stop smoking due to safety reasons and R1's cigarettes were removed from her room. R1's Behavior Charting dated 9/2/24 at 8:36 a.m., identified R1 went to another resident's room and took cigarettes. R1 returned to her room and started smoking the cigarettes. During observation and interview on 9/24/24 at 11:55 a.m., R1 was sitting on the bed with a pack of cigarettes and a lighter sitting next to her on the bed. R1 stated a friend gave them to her. R1 admitted to going outside to smoke about 4-5 times a day and did not have staff with her when she smokes. R1 denied knowing that she was	F 689		

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F 689	Continued From page 13 not to smoke. During an observation on 9/24/24 at 1:17 p.m., R1 wheeled independently outside to the designated smoking area. R1 was observed sitting in her wheelchair on the sidewalk by the rock garden, lighting, and smoking two cigarettes with no observation of staff supervision. Five other residents were outside smoking in the same area. R1 re-entered the facility at 1:36 p.m. During an interview on 9/23/24 at 2:00 p.m., R2 described R1 punching her in the nose on 9/1/24. R2 indicated the facility took R1's cigarettes away so R1 would beg or steal other resident's cigarettes. R2 further explained she was putting her cigarette butt into the disposal receptacle when R1 tried to take the butt out of the receptacle, R2 attempted to put an ice cube in the receptacle when R1 punched her in the face. R2 denied any staff supervision while R1 was smoking that day. During an interview on 9/23/24 at 1:35 p.m., R3 shared an incident occurred on 8/31/24, when R1 and R3 were in the outside smoking area and R1 "took a big rock and smashed my ankle three times". Further indicated staff were not present at the time of the incident and the facility staff continued to allow R1 go out to the smoking area 3-4 times a day without supervision. During an interview on 9/23/24 at 2:50 p.m., nursing assistant (NA)-A indicated that R1 was observed falling asleep with a lit cigarette and ashes would drop on her clothes. Further indicated R1 was supposed to wear a smoking apron but refused. NA-A identified the new plan was to check on R1 "every 5 minutes or so but	F 689		

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F 689	Continued From page 14 she is quick, and we do not always know she is out there [smoking area]". During an interview on 9/23/24 at 3:04 p.m., registered nurse (RN)-A indicated the facility has tried to take R1's cigarettes away but she keeps getting them. Further identified R1 is not safe to smoke independently and they "try to have someone with her but that is not always possible". During an interview on 9/23/24 at 3:30 p.m., R4 indicated R1 did not always have staff supervision outside and would try to steal other resident's cigarettes and lighters. During an interview on 9/23/24 at 3:35 p.m., R5 indicated R1 did not have staff supervision when smoking outside. During an interview on 9/23/24 at 3:49 p.m., R6 indicated staff do not supervise R1 while smoking outside. During an interview on 9/23/24 at 4:00 p.m., Social Service Designee (SSD) indicated R1 should not have a lighter or cigarettes, but the facility cannot control what gets brought into the building. R1 has been noted to smoke in the building at times. SSD indicated R1 could go outside to the smoking area to smoke without supervision but had to be monitored by staff. The SSD explained she did not know how often the staff were monitoring R1 while smoking. During an interview on 9/24/24 at 9:14 a.m., R1's primary medical doctor (MD) indicated he did not recall writing an order that R1 could not smoke but was concerned more about her safety risk for smoking. R1's MD further indicated R1 is a	F 689		

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F 689	Continued From page 15 danger to the other residents and herself and staff should always be supervising R1 during smoking. During an interview on 9/24/24 at 11:22 a.m., NA-B indicated R1 did go outside to smoke independently but after the first incident the facility started 1:1's but R1 was quick and got outside without staff knowing. Further identified that R1 continued to smoke outside without supervision and stated, "nobody said anything to me, so I have not been physically watching her smoke". During an interview on 9/24/24 at 12:06 p.m., NA-C stated if R1 goes outside to smoke, "we are supposed to check on her every so often to make sure she is safe and that everyone else around her is ok having her (R1) around". NA-C further indicated there was not a certain time limit to check on her, just every so often so it depended how busy the staff were. During an interview on 9/24/24 at 1:06 p.m., licensed practical nurse (LPN)-A stated, R1 "had her own cigarettes and staff tried to catch her when she went outside to smoke and check on her once in a while". LPN-A indicated R1 did not have 15-minute safety checks and did not know where the safety checks would be documented. During an interview on 9/24/24 at 11:55 a.m., director of nursing (DON) indicated R1 could go out and smoke independently until the 9/1/24 incident (resident to resident abuse). The DON further indicated after that incident, staff were supposed to physically be with R1 when outside smoking, but staff cannot always catch R1 when she goes out to smoke.	F 689		

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F 689	Continued From page 16 The facility's policy titled, Resident Smoking Policy last revised 8/24, indicated it is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protection apply to smoking and non-smoking residents. Compliance guidelines include: Residents who smoke will be further assessed using the Resident Assessment to determine whether supervision is required for smoking, or if resident is safe to smoke at all. Any resident who is deemed safe to smoke with or without supervision, will be allowed to smoke in designated smoking areas, at designated times, and in accordance with his/her care plan. If a resident who smokes experiences any decline in condition or cognition, he/she will be reassessed for ability to smoke independently and/or evaluated whether any additional safety measure are indicated. Smoking materials of residents requiring supervision with smoking will be maintained by nursing staff. The interdisciplinary team, with guidance from the physician, will help to support the resident's right to make an informed decision regarding smoking by including the resident, family, or representative regarding the risk associated with smoking; offering pharmacological and/or behavioral interventions to assist with smoking cessation; developing a safe smoking plan, or an individualized plan to quit smoking. The facility's undated policy titled Smoking Policy-Residents, indicated the facility has established and maintains safe resident smoking practices. Cigarette butts and lighters are not	F 689		

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F 689	Continued From page 17 permitted in the building. Violations will result in smoking privileges being revoked. Personal lighters will be held at the nurse's station. Resident smoking status is evaluation upon admission. If a smoker, the evaluation includes current level of tobacco consumption, method of tobacco consumption, desire to quit smoking, ability to smoke safely with or without supervision (per a completed Safe Smoking Evaluation). The staff consults with the attending physician and the DON to determine if safety restrictions need to be placed on a resident's smoking privileges based on ... ... this was the end of the policy with no further information provided by facility.	F 689		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/23/24 and 9/24/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H54008040C (MN00106314); H54008041C (MN00106326); H54008761C (MN00106848); and H54008900C (MN00106934) with a licensing order issued at 0830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility	2 000		

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2 000	Continued From page 2 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to implement and provide adequate supervision and safety interventions for 1 of 3 residents (R1) reviewed for smoking. Findings include R1's quarterly Minimum Data Set (MDS) dated 8/16/24, indicated R1 had moderate cognitive	2 830	Corrected	10/24/24

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	00949	A. BUILDING: _____ B. WING _____	C 09/24/2024

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2 830	Continued From page 3 impairment, did not have sign/symptoms of delirium, and did not have behaviors. The MDS further indicated R1 was independent with walking, toileting, transferring, and personal cares with no upper or lower body impairments. Diagnoses included anemia, diabetes, depression, histrionic personality disorder (a mental health condition characterized by overwhelming desire to be noticed and dramatic behavior), nicotine dependence, and mild cognitive impairment. R1's care plan last updated 8/29/24, indicated R1 had been deemed unsafe to smoke by her physician. The goal was that R1 will not smoke. The interventions were to review smoking policy as needed and with any changes, R1 cannot smoke unsupervised and independently, and notify charge nurse immediately if it is suspected R1 has violated facility smoking policy. The care plan also identified R1 had a potential to be verbally aggressive, yelling, and had an actual physical altercation with another resident. The interventions updated on 9/1/24, identified R1 needed 1:1 staff supervision always when resident was outside in the smoking area. R1's Smoking Review dated 8/16/24, indicated R1 smoked 3-4 times a day and had a history of smoking related incidents such as burning clothing, smoking in bed, and dropping ashes on self. The recommendation was R1 not safe to smoke and provider notified. R1's Nursing Note on 8/28/24 at 1:44 p.m., indicated R1 was informed of the safety concerns observed while smoking and not passing the smoking assessment. Offered nicotine patches/gun [gum] but refused. Will continue to monitor/educate on safe smoking.	2 830		

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2 830	Continued From page 4 R1's Physician's Note dated 8/28/24 at 10:42 p.m., identified R1 was observed falling asleep while walking with a cigarette in her mouth. Plan was to notify R1's guardian of the need to revoke smoking privileges due to safety concerns and of the possible need for new placement as R1 was likely to refuse cessation of smoking privileges. R1's Social Service Note dated 8/29/24 at 5:27 p.m., identified R1 was told she was not able to smoke anymore due to doctor's orders. R1 became verbally and physically upset. R1's daughter and guardian were notified R1 was to stop smoking due to safety reasons and R1's cigarettes were removed from her room. R1's Behavior Charting dated 9/2/24 at 8:36 a.m., identified R1 went to another resident's room and took cigarettes. R1 returned to her room and started smoking the cigarettes. During observation and interview on 9/24/24 at 11:55 a.m., R1 was sitting on the bed with a pack of cigarettes and a lighter sitting next to her on the bed. R1 stated a friend gave them to her. R1 admitted to going outside to smoke about 4-5 times a day and did not have staff with her when she smokes. R1 denied knowing that she was not to smoke. During an observation on 9/24/24 at 1:17 p.m., R1 wheeled independently outside to the designated smoking area. R1 was observed sitting in her wheelchair on the sidewalk by the rock garden, lighting, and smoking two cigarettes with no observation of staff supervision. Five other residents were outside smoking in the same area. R1 re-entered the facility at 1:36 p.m.	2 830		

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2 830	Continued From page 5 During an interview on 9/23/24 at 2:00 p.m., R2 described R1 punching her in the nose on 9/1/24. R2 indicated the facility took R1's cigarettes away so R1 would beg or steal other resident's cigarettes. R2 further explained she was putting her cigarette butt into the disposal receptacle when R1 tried to take the butt out of the receptacle, R2 attempted to put an ice cube in the receptacle when R1 punched her in the face. R2 denied any staff supervision while R1 was smoking that day. During an interview on 9/23/24 at 1:35 p.m., R3 shared an incident occurred on 8/31/24, when R1 and R3 were in the outside smoking area and R1 "took a big rock and smashed my ankle three times". Further indicated staff were not present at the time of the incident and the facility staff continued to allow R1 go out to the smoking area 3-4 times a day without supervision. During an interview on 9/23/24 at 2:50 p.m., nursing assistant (NA)-A indicated that R1 was observed falling asleep with a lit cigarette and ashes would drop on her clothes. Further indicated R1 was supposed to wear a smoking apron but refused. NA-A identified the new plan was to check on R1 "every 5 minutes or so but she is quick, and we do not always know she is out there [smoking area]". During an interview on 9/23/24 at 3:04 p.m., registered nurse (RN)-A indicated the facility has tried to take R1's cigarettes away but she keeps getting them. Further identified R1 is not safe to smoke independently and they "try to have someone with her but that is not always possible". During an interview on 9/23/24 at 3:30 p.m., R4 indicated R1 did not always have staff supervision	2 830		

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2 830	Continued From page 6 outside and would try to steal other resident's cigarettes and lighters. During an interview on 9/23/24 at 3:35 p.m., R5 indicated R1 did not have staff supervision when smoking outside. During an interview on 9/23/24 at 3:49 p.m., R6 indicated staff do not supervise R1 while smoking outside. During an interview on 9/23/24 at 4:00 p.m., Social Service Designee (SSD) indicated R1 should not have a lighter or cigarettes, but the facility cannot control what gets brought into the building. R1 has been noted to smoke in the building at times. SSD indicated R1 could go outside to the smoking area to smoke without supervision but had to be monitored by staff. The SSD explained she did not know how often the staff were monitoring R1 while smoking. During an interview on 9/24/24 at 9:14 a.m., R1's primary medical doctor (MD) indicated he did not recall writing an order that R1 could not smoke but was concerned more about her safety risk for smoking. R1's MD further indicated R1 is a danger to the other residents and herself and staff should always be supervising R1 during smoking. During an interview on 9/24/24 at 11:22 a.m., NA-B indicated R1 did go outside to smoke independently but after the first incident the facility started 1:1's but R1 was quick and got outside without staff knowing. Further identified that R1 continued to smoke outside without supervision and stated, "nobody said anything to me, so I have not been physically watching her smoke".	2 830		

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2 830	Continued From page 7 During an interview on 9/24/24 at 12:06 p.m., NA-C stated if R1 goes outside to smoke, "we are supposed to check on her every so often to make sure she is safe and that everyone else around her is ok having her (R1) around". NA-C further indicated there was not a certain time limit to check on her, just every so often so it depended how busy the staff were. During an interview on 9/24/24 at 1:06 p.m., licensed practical nurse (LPN)-A stated, R1 "had her own cigarettes and staff tried to catch her when she went outside to smoke and check on her once in a while". LPN-A indicated R1 did not have 15-minute safety checks and did not know where the safety checks would be documented. During an interview on 9/24/24 at 11:55 a.m., director of nursing (DON) indicated R1 could go out and smoke independently until the 9/1/24 incident (resident to resident abuse). The DON further indicated after that incident, staff were supposed to physically be with R1 when outside smoking, but staff cannot always catch R1 when she goes out to smoke. The facility's policy titled, Resident Smoking Policy last revised 8/24, indicated it is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protection apply to smoking and non-smoking residents. Compliance guidelines include: Residents who smoke will be further assessed using the Resident Assessment to determine whether supervision is required for smoking, or if resident is safe to smoke at all. Any resident who is deemed safe to smoke with or without	2 830		

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2 830	Continued From page 8 supervision, will be allowed to smoke in designated smoking areas, at designated times, and in accordance with his/her care plan. If a resident who smokes experiences any decline in condition or cognition, he/she will be reassessed for ability to smoke independently and/or evaluated whether any additional safety measure are indicated. Smoking materials of residents requiring supervision with smoking will be maintained by nursing staff. The interdisciplinary team, with guidance from the physician, will help to support the resident's right to make an informed decision regarding smoking by including the resident, family, or representative regarding the risk associated with smoking; offering pharmacological and/or behavioral interventions to assist with smoking cessation; developing a safe smoking plan, or an individualized plan to quit smoking. The facility's undated policy titled Smoking Policy-Residents, indicated the facility has established and maintains safe resident smoking practices. Cigarette butts and lighters are not permitted in the building. Violations will result in smoking privileges being revoked. Personal lighters will be held at the nurse's station. Resident smoking status is evaluation upon admission. If a smoker, the evaluation includes current level of tobacco consumption, method of tobacco consumption, desire to quit smoking, ability to smoke safely with or without supervision (per a completed Safe Smoking Evaluation). The staff consults with the attending physician and the DON to determine if safety restrictions need to be placed on a resident's smoking privileges based on ... ... this was the end of the policy with no further information provided by facility.	2 830		

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2 830	Continued From page 9 SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure residents who smoke not on the smoke-free campus are supervised appropriately for safety. The administrator or designee should also ensure if smoking is allowed, residents are supplied with a smoking receptacle to discard cigarettes. The facility should re-educate all staff identified to policies and procedures, and audit residents who smoke to determine safety and supervision occured. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: 21 DAYS	2 830		