Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 31, 2024

Administrator
The Villas At Richfield
7727 Portland Avenue South
Richfield, MN 55423

RE: CCN: 245492
Cycle Start Date: November 27, 2023

Dear Administrator:

On January 24, 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.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 5, 2023

Administrator
The Villas At Richfield
7727 Portland Avenue South
Richfield, MN 55423

RE: CCN: 245492
Cycle Start Date: November 27, 2023

Dear Administrator:

On November 27, 2023, a survey was completed at your facility by the Minnesota Department 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 February 27, 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 May 27, 2024 (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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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Electronically delivered

December 5, 2023

Administrator
The Villas At Richfield
7727 Portland Avenue South
Richfield, MN 55423

Re: Event ID: 28ZG11

Dear Administrator:

The above facility survey was completed on November 27, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245492	A. BUILDING _____ B. WING _____	C 11/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT RICHFIELD	7727 PORTLAND AVENUE SOUTH RICHFIELD, MN 55423

(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 11/22/23 & 11/27/23, 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. H54927217C (MN00098616) with a deficiency issued at F656. 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 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 656		1/3/24

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

Electronically Signed | 12/11/2023

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 656	Continued From page 1 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to develop and implement a comprehensive care plan for 3 of 3 residents reviewed for comprehensive care plans when residents did not comply with their care planned	F 656	R1 was provided risks vs benefits regarding not smoking at the facility per resident's careplan. R1's room was searched with resident consent to ensure resident did not have any smoking	

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F 656	Continued From page 2 smoking interventions. Findings include: R1's quarterly Minimum Data Set (MDS) dated 8/9/23, noted R1 had moderately impaired cognition, required the assistance for bed mobility, transfers, bathing, dressing and is non-ambulatory. R1's diagnoses included encephalopathy (a disease that alters brain function), hemiplegia, dysphagia, and weakness. R1's smoking evaluation dated 10/18/23, noted R1 identified as a smoker but was deemed unsafe to store/handle his own cigarette and lighter due to cognitive loss, dexterity problems, inability to light his own cigarette and noted cigarette ashes on his clothing. R1's care plan initiated on 10/24/23, noted R1 was a smoker but was not a safe smoker, unable to store/handle his own cigarettes and lighter, and that he will not smoke at the facility. R4's quarterly MDS dated 10/5/23, noted R4 had mildly impaired cognition, required assistance with activities of daily living (ADL's) and had diagnoses that included malignant neoplasm of part of the lung (lung cancer), pneumothorax (collapsed lung), abnormal posture and chronic obstructive pulmonary disease (COPD). R4's smoking evaluation dated 10/4/23, noted R4 identified as a smoker, had cognitive deficits and was able to smoke independently without adaptive equipment. R4's care plan initiated on 10/26/23, noted R4 was a smoker and was required to wear an apron	F 656	materials at the facility. R4 was provided risks vs benefits regarding wearing smoking apron per resident's careplan. R5 had a new smoking assessment completed and resident was deemed appropriate to no longer require a smoking apron. R5's careplan updated to reflect smoking assessment. All residents who smoke were re-educated on smoking policy specifically on not assisting other residents with smoking. All residents who smoke have the potential to be affected. All smoking evaluations for the residents who smoke have been reviewed and pertinent interventions have been careplanned. Smoking policy and care planning policy have been reviewed and remain current. Nursing staff and social services staff to be educated on smoking policy and care planning policy. DON or designee will audit 5 random resident's smoking assessments and careplans for accuracy for smoking interventions per week x 4 weeks. DON or designee will audit 5 random residents smoking to ensure care plan is being followed per week x 4 weeks. The results of these audits will be shared with facility QAPI committee for input on need to increase, decrease, or discontinue audits.	

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F 656	Continued From page 3 when smoking. R4's progress note dated 10/27/23, noted R4 was reminded to wear smoking apron before she smokes, R4 refused to wear it and told staff that she gave it away when asked where the apron was. Social services met with R4 provided education on the smoking policy and had R4 sign it. R5's annual MDS dated 8/16/23, noted R5 had intact cognition, required assistance with ADL's and had diagnoses that included weakness, type 2 diabetes mellitus, difficulty walking and lymphedema. R5's smoking evaluation dated 11/15/23, noted R5 identified as a smoker, did not have cognitive, visual or dexterity deficits, was able to light her own cigarette and was deemed safe to store/handle her own cigarette/lighter but required a smoking apron. R5's care plan initiated on 12/3/21, noted R5 was independent with smoking and did not have need any adaptive equipment. During an observation on 11/22/23, at 10:09 a.m. R1 was assisted outside to the smoking area by another resident, he was smoking a cigarette by the door and after extinguishing it was assisted back inside the facility by another resident. During an interview on 11/22/23, with R1 at 1:14 p.m. R1 stated he was a smoker and went outside to smoke often and that he does not smoke in his room because his roommate is on oxygen. During the interview, there were 3 cigarettes on R1's nightstand and another 2	F 656		

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F 656	Continued From page 4 cigarettes on his dresser next to his television observed in his bedroom. During an interview on 11/27/23, at 10:10 a.m. Registered Nurse (RN)-A stated she was from a staffing agency, this was her first day at the facility and did not know which residents identified as smokers. During an interview on 11/27/23, at 11:49 a.m. nursing assistant (NA)-A stated she did not know all the residents that smoke at the facility on that floor but was able to name several and that there used to be a list at the nursing station but there was not one there any longer. During an observation on 11/27/23, at 12:42 p.m. R5 was outside in the smoking area, she is not wearing a smoking apron. During an interview on 11/27/23, at 12:45 p.m. R5 stated she had a safe smoking assessment and was told she needed to wear a smoking apron when she was smoking but she does not use it because it was a hassle and other smokers say "stupid things" when you have one on. During an interview on 11/27/23, at 1:28 p.m. R4 stated she was a smoker, was not sure if the facility did a safe smoking assessment but that she was told she needed to wear a smoking apron but that she refused to wear it. R4 stated the smoking apron was uncomfortable and they looked stupid, she stated she took it off and put it on a table and did not know where it was. R4 additionally stated she had been smoking without it and was not sure if staff were doing anything differently since she didn't wear it.	F 656		

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F 656	Continued From page 5 During an observation on 11/27/23, at 3:08 p.m. R1 is in his wheelchair in the hallway with 2 cigarettes on the left armrest. Several staff stop to talk with him, none address the cigarettes. During an observation on 11/27/23, at 3:45 p.m. the administrator pushed R1 down the hall towards his room and does not remove or address the cigarettes. During an interview on 11/27/23, at 4:00 p.m. the director or nursing (DON) stated she had not recalled seeing R1 outside smoking at the facility, R4's smoking assessment was likely an error and the staff assessing should have clicked the box for smoking apron. The addition for a smoking apron was added to her care plan that day, likely by a nurse manager. The DON stated she expects a residents care plan to match the smoking assessments and if a resident was refusing an intervention then a risk versus benefit form would be completed. The DON confirmed there were no risk versus benefit forms completed for R1, R4 or R5. She stated she expected nursing staff to notify management, the provider and to document in a progress note any resident refusal of safe smoking interventions. A facility policy titled Care Planning last revised on 1/6/22, noted the interdisciplinary team (IDT) will develop and implement a comprehensive individualized care plan. Additionally, the care plan should be used in developing the residents daily care routines and will be utilized by staff.	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	C 11/27/2023

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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 11/22/23 & 11/27/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure The following complaints were reviewed during	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00253	A. BUILDING: _____ B. WING _____	C 11/27/2023

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2 000	Continued From page 1 the survey. H54927217C (MN00098616) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		

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F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 656		1/3/24

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

Electronically Signed | 12/11/2023

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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THE VILLAS AT RICHFIELD	7727 PORTLAND AVENUE SOUTH RICHFIELD, MN 55423

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F 656	Continued From page 1 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to develop and implement a comprehensive care plan for 3 of 3 residents reviewed for comprehensive care plans when residents did not comply with their care planned	F 656	R1 was provided risks vs benefits regarding not smoking at the facility per resident's careplan. R1's room was searched with resident consent to ensure resident did not have any smoking	

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	245492	A. BUILDING _____ B. WING _____	C 11/27/2023

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F 656	Continued From page 2 smoking interventions. Findings include: R1's quarterly Minimum Data Set (MDS) dated 8/9/23, noted R1 had moderately impaired cognition, required the assistance for bed mobility, transfers, bathing, dressing and is non-ambulatory. R1's diagnoses included encephalopathy (a disease that alters brain function), hemiplegia, dysphagia, and weakness. R1's smoking evaluation dated 10/18/23, noted R1 identified as a smoker but was deemed unsafe to store/handle his own cigarette and lighter due to cognitive loss, dexterity problems, inability to light his own cigarette and noted cigarette ashes on his clothing. R1's care plan initiated on 10/24/23, noted R1 was a smoker but was not a safe smoker, unable to store/handle his own cigarettes and lighter, and that he will not smoke at the facility. R4's quarterly MDS dated 10/5/23, noted R4 had mildly impaired cognition, required assistance with activities of daily living (ADL's) and had diagnoses that included malignant neoplasm of part of the lung (lung cancer), pneumothorax (collapsed lung), abnormal posture and chronic obstructive pulmonary disease (COPD). R4's smoking evaluation dated 10/4/23, noted R4 identified as a smoker, had cognitive deficits and was able to smoke independently without adaptive equipment. R4's care plan initiated on 10/26/23, noted R4 was a smoker and was required to wear an apron	F 656	materials at the facility. R4 was provided risks vs benefits regarding wearing smoking apron per resident's careplan. R5 had a new smoking assessment completed and resident was deemed appropriate to no longer require a smoking apron. R5's careplan updated to reflect smoking assessment. All residents who smoke were re-educated on smoking policy specifically on not assisting other residents with smoking. All residents who smoke have the potential to be affected. All smoking evaluations for the residents who smoke have been reviewed and pertinent interventions have been careplanned. Smoking policy and care planning policy have been reviewed and remain current. Nursing staff and social services staff to be educated on smoking policy and care planning policy. DON or designee will audit 5 random resident's smoking assessments and careplans for accuracy for smoking interventions per week x 4 weeks. DON or designee will audit 5 random residents smoking to ensure care plan is being followed per week x 4 weeks. The results of these audits will be shared with facility QAPI committee for input on need to increase, decrease, or discontinue audits.	

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F 656	Continued From page 3 when smoking. R4's progress note dated 10/27/23, noted R4 was reminded to wear smoking apron before she smokes, R4 refused to wear it and told staff that she gave it away when asked where the apron was. Social services met with R4 provided education on the smoking policy and had R4 sign it. R5's annual MDS dated 8/16/23, noted R5 had intact cognition, required assistance with ADL's and had diagnoses that included weakness, type 2 diabetes mellitus, difficulty walking and lymphedema. R5's smoking evaluation dated 11/15/23, noted R5 identified as a smoker, did not have cognitive, visual or dexterity deficits, was able to light her own cigarette and was deemed safe to store/handle her own cigarette/lighter but required a smoking apron. R5's care plan initiated on 12/3/21, noted R5 was independent with smoking and did not have need any adaptive equipment. During an observation on 11/22/23, at 10:09 a.m. R1 was assisted outside to the smoking area by another resident, he was smoking a cigarette by the door and after extinguishing it was assisted back inside the facility by another resident. During an interview on 11/22/23, with R1 at 1:14 p.m. R1 stated he was a smoker and went outside to smoke often and that he does not smoke in his room because his roommate is on oxygen. During the interview, there were 3 cigarettes on R1's nightstand and another 2	F 656		

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F 656	Continued From page 4 cigarettes on his dresser next to his television observed in his bedroom. During an interview on 11/27/23, at 10:10 a.m. Registered Nurse (RN)-A stated she was from a staffing agency, this was her first day at the facility and did not know which residents identified as smokers. During an interview on 11/27/23, at 11:49 a.m. nursing assistant (NA)-A stated she did not know all the residents that smoke at the facility on that floor but was able to name several and that there used to be a list at the nursing station but there was not one there any longer. During an observation on 11/27/23, at 12:42 p.m. R5 was outside in the smoking area, she is not wearing a smoking apron. During an interview on 11/27/23, at 12:45 p.m. R5 stated she had a safe smoking assessment and was told she needed to wear a smoking apron when she was smoking but she does not use it because it was a hassle and other smokers say "stupid things" when you have one on. During an interview on 11/27/23, at 1:28 p.m. R4 stated she was a smoker, was not sure if the facility did a safe smoking assessment but that she was told she needed to wear a smoking apron but that she refused to wear it. R4 stated the smoking apron was uncomfortable and they looked stupid, she stated she took it off and put it on a table and did not know where it was. R4 additionally stated she had been smoking without it and was not sure if staff were doing anything differently since she didn't wear it.	F 656		

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F 656	Continued From page 5 During an observation on 11/27/23, at 3:08 p.m. R1 is in his wheelchair in the hallway with 2 cigarettes on the left armrest. Several staff stop to talk with him, none address the cigarettes. During an observation on 11/27/23, at 3:45 p.m. the administrator pushed R1 down the hall towards his room and does not remove or address the cigarettes. During an interview on 11/27/23, at 4:00 p.m. the director or nursing (DON) stated she had not recalled seeing R1 outside smoking at the facility, R4's smoking assessment was likely an error and the staff assessing should have clicked the box for smoking apron. The addition for a smoking apron was added to her care plan that day, likely by a nurse manager. The DON stated she expects a residents care plan to match the smoking assessments and if a resident was refusing an intervention then a risk versus benefit form would be completed. The DON confirmed there were no risk versus benefit forms completed for R1, R4 or R5. She stated she expected nursing staff to notify management, the provider and to document in a progress note any resident refusal of safe smoking interventions. A facility policy titled Care Planning last revised on 1/6/22, noted the interdisciplinary team (IDT) will develop and implement a comprehensive individualized care plan. Additionally, the care plan should be used in developing the residents daily care routines and will be utilized by staff.	F 656		