Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306758888M
Compliance #: HL306756507C

Date Concluded: April 8, 2024

Name, Address, and County of Licensee Investigated:
Laurels Edge Assisted Living
77 Stadium Road
Mankato, MN 56001
Blue Earth County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Erin Johnson-Crosby, RN
Special Investigator

Finding: Not Substantiated

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected the resident when facility staff did not implement interventions to prevent wounds. The resident was hospitalized with a toe wound with maggots.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident developed a toe wound, there was not a preponderance of evidence to support that neglect occurred. When staff discovered the wound, staff assessed and treated the area and scheduled a podiatry appointment for further evaluation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's records, hospital records, staff schedules, and facility policies and procedures. Also, the investigator observed resident care and services at the time of the onsite visit.

The resident resided in an assisted living memory care unit. The resident had a diagnosis of dementia. The resident's service plan included assistance with morning and evening cares, dressing, grooming, toileting, and behavior support.

Upon admission to the facility, the resident was noted to have poor hygiene and staff immediately assisted the resident with bathing. The resident's admission assessment indicated the resident's groin and buttocks area were slightly pink from not bathing for months. No other skin concerns were noted. The assessment indicated the resident should be seen by podiatry to assess and care for her feet and toenails.

Two weeks later, the nurse scheduled an appointment for the resident to be seen by the in-house podiatry team. The next day, the nurse was informed of redness and discharge on the resident's right toe. Later that day, staff found maggots under the resident's toenails and the resident was sent to the emergency department for further evaluation.

The resident was hospitalized for two days for a right toe pressure injury (ulcer) and cellulitis (skin infection) and started on antibiotics. One month later, the wound on the right toe was almost healed, with no signs or symptoms of infection.

During an interview, the nurse stated that upon admission she was concerned with the appearance of the resident's toes and toenails, so she added the resident to the list to be seen by the facility's in-house podiatry team. The nurse stated the skin between the resident's toenails was intact upon admission. The nurse stated when she was informed of the open area on the resident's toes, she cleansed the area and scheduled a podiatry appointment for the next day. When staff found maggots on the resident's nails, she called 911 and had the resident sent to the emergency room.

During an interview, a second facility nurse stated when the resident admitted to the facility, they were informed she had not been seen by a doctor in twenty years. The resident admitted with poor hygiene and long toenails. The nurse stated she completed an admission skin assessment, and the toe wound was not noted at that time.

During an interview, the resident's family member stated the resident was living in an unsafe and unclean environment prior to admission to the facility. The family member stated he had no concerns with the care provided by the facility and felt the facility did nothing wrong in this situation.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
“Neglect” means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No, due to cognitive impairment.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The resident was sent to the emergency room for further evaluation.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30675	A. BUILDING: _____ B. WING _____	C 02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELS EDGE ASSISTED LIVING	77 STADIUM ROAD MANKATO, MN 56001

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL306755262C/# HL306758145M, #HL306754483C/#HL306757684M, #HL306756507C/#HL306758888M On February 13, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 40 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for: #HL306755262C/# HL306758145M, #HL306754483C/#HL306757684M, #HL306756507C/#HL306758888M tag identification 0495, 1620, 2310. #HL306756507C/#HL306758888M tag	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is 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. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL	

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0 000	Continued From page 1 identification 0630.	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 495 SS=F	144G.41 Subd. 1 (14) Minimum Requirements (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide staff access to an on-call registered nurse (RN) 24 hours per day, seven days per week. This had the potential to affect all 40 residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's January 2024, nurse on-call calendar indicated a licensed practical nurse (LPN) was the nurse on-call 25 out of 31 days. The calendar did not include a number for a registered nurse (RN). The licensee's February 2024, nurse on-call schedule indicated a LPN was the nurse on call for 23 out of 29 days. The calendar did not include a number for a RN.	0 495	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is 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	

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0 495	Continued From page 2 On February 23, 2024, at 1:08 p.m., unlicensed personnel (ULP)-B stated the on-call schedule was posted and it was usually a LPN on-call. ULP-B stated for a long time, there also was not a RN onsite. On February 13, 2024, at 1:05 p.m., LPN-C stated she would contact the RN with any immediate concerns, but there was no procedure on when to contact the RN. On February 13, 2024, at 1:55 p.m., the facility clinical supervisor registered nurse (RN)-J stated there did not need to be a RN on-call and did not know when the LPN would need to contact the RN. The licensee's On-Call Nurse Policy dated August 1, 2021, indicated the staff would have access to an on-call RN 24 hours per day, seven days per week. The policy also indicated LPN's were able to take call, with the expectation that the LPN will reach out to the RN as appropriate. The policy did not include when the LPN was required to notify a RN. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 495	VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the	0 630		

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0 630	Continued From page 3 person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individual abuse prevention plan (IAPP) with the required content for one of four residents (R4) reviewed. R4's IAPP was not updated to reflect R4's ability to smoke safely and independently and was not updated with interventions to ensure R4's safety with smoking after concerns were identified. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R4 diagnoses included dementia, heart disease, and chronic obstructive pulmonary disease. R4's assessment was dated October 20, 2022, and was completed by a LPN. R4's Admission Vulnerable Adult/Individualized Abuse Prevention Plan (IAPP) dated August 22,	0 630		

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0 630	Continued From page 4 2022, indicated R4 was safe with smoking and included a goal that R4 would not suffer from injuries related to unsafe smoking or oxygen use. The assessment was completed by a licensed practical nurse (LPN). There was no evidence that an observation of R4 was completed at the time of the assessment. R4's vulnerability assessment dated October 20, 2022, and indicated R4 was safe smoking. R4's most recent assessment RN annual assessment was dated August 16, 2023 indicated R4 was a current every day smoker. The assessment did not identify if R4 was observed smoking at the time of the assessment, if R4 was a safe, independent smoker, or if R4 required assistance with smoking R4's service plan dated February 1, 2024, included services for daily cares, behavior support, med administration, transferring, and toileting. R4's progress notes dated April 18, 2023, indicated in the past two weeks R4 had been smoking in the front entrance of the building and does not seem to remember that she is not supposed to smoke in the building. R4's medical record lacked documentation a registered nurse (RN) was notified of R4 smoking in the front of the building. R4's medical record was not updated to include a smoking assessment, or observation of R4 smoking to determine if R4 was safe to smoke independently, and R4's IAPP was not updated. R4's progress note dated February 11, 2024, indicated staff notified the licensed practical nurse	0 630		

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0 630	Continued From page 5 (LPN) and indicated there was a strong smell of cigarette smoking coming from R4's bathroom. LPN-C told staff to remove R4's cigarettes and lighters and give R4 a cigarette when requested. After that, R4 was found smoking in the front entry way of the building. R4's medical record lacked documentation a registered nurse (RN) was notified of R4 smoking in the front of the building. R4's medical record was not updated to include a smoking assessment, or observation of R4 smoking to determine if R4 was safe to smoke independently, and R4's IAPP was not updated. On February 13, 2024, the investigator observed R4 outside smoking. R4 put out her cigarette in a trash receptacle that was located under an awning that was attached to the facility and approximately three feet from the facility. The trash bin was filled with garbage. When R4 entered the facility, the investigator noticed burn holes on R4's coat. When questioned about the burn holes, R4 stated, "Oh, I probably do." When questioned about putting the cigarette out in the trash, R4 replied, "I make sure it is out before I put it in there." On February 13, 2024, at 12:26 p.m., LPN-C stated she was notified over the weekend that R4 was smoking in the building. LPN-C stated she did not perform a smoking assessment after she was notified of this information. LPN-C stated the cigarette should be disposed of in a metal trash can and not a plastic trash can with trash in it. LPN-C confirmed the RN was not updated after LPN-C was informed of R4 smoking over the weekend. On February 13, 2024, at 3:33 p.m., facility	0 630		

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0 630	Continued From page 6 clinical supervisor registered nurse (RN)-J confirmed R4's IAPP was not updated after previous smoking concerns were observed and documented, but she completed a smoking assessment today and R4's assessment indicated the need for R4 to wear a smoking apron. RN-J observed R4 smoking and noted when R4 lit her cigarette, the lit cigarette hit R4 clothes since R4 hunched over. RN-J stated a smoking apron would protect R4 from burns. On February 14, 2024, 9:30 a.m., Assisted Living Corporate Nurse Lead Registered Nurse (RN)-G stated the IAPP that included the smoking assessment should be completed yearly or with a change in condition. RN-G stated if a resident is smoking in the building, a smoking assessment should be completed. The licensee's Assessment- Schedule Policy dated August 26, 2021, did not include when an IAPP should be completed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 630		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living	01620		

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01620	Continued From page 7 services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, not to exceed 90 calendar days from the last date of the assessment, for three of four residents (R1, R2, and R4). In addition, the licensee failed to ensure a RN completed a change in condition assessment for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	01620		

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01620	Continued From page 8 R1 R1's diagnoses included dementia with behavioral disturbance, and heart failure. R1's undated service plan indicated services included assistance with morning and evening cares, medication administration, toileting, behavior support, and safety checks. R1's vulnerability assessment/abuse prevention plan, dated October 5, 2021, was completed by the LPN. R1's annual RN assessment, dated October 20, 2022, was completed by a licensed practical nurse (LPN). R1's next assessment was not completed by a RN until June 9, 2023. R1 was discharged on August 3, 2023. R2 R2's diagnoses included Wernicke encephalopathy and delusional disorder. R2's undated service plan included assistance with morning and evening cares, bathing, behavior support, safety checks, med administration, wound care as needed, and toileting. R2's most recent RN annual assessment was dated November 11, 2022, and completed by the LPN. R2's record did not include an updated assessment completed by a RN.	01620		

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01620	Continued From page 9 R2's progress notes indicated R2 discharged on August 24, 2023, to the hospital for a necrotic wound, with bone exposed and maggots. R2's record did not include a RN wound assessment, documentation or monitoring. R3 R3's diagnoses included dementia and chronic kidney disease. R3's service plan dated September 18, 2023, indicated services included assistance with activities of daily living, bathing, behavior support, toileting and medication administration. R3's progress notes dated October 4, 2023, indicated the LPN was notified R3's nails had maggots on them. R3 was sent to the emergency room. R3's progress notes dated October 5, 2023, indicated R3 was admitted to the hospital and awaiting podiatry to trim toenails. R3's progress notes dated October 6, 2023, indicated R3 was treated with intravenous antibiotics and would continue oral antibiotics. R3's orders included an acidic acid wash between her toes, antifungal cream and gauze between her toes. The note also indicated the resident returned to the facility. R3's record lacked evidence that the RN completed a change in condition assessment following R3's return to the facility after the hospitalization. R3's record also lacked evidence that the RN completed a wound assessment upon R3's return	01620		

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01620	Continued From page 10 to the facility. R3 returned to the facility with orders for facility staff to complete wound care. R4 R4 diagnoses included dementia, heart disease, chronic obstructive pulmonary disease, R4's RN 14-day assessment was dated October 20, 2022, was completed by a LPN. R4's most recent RN annual assessment was not completed by the RN until August 16, 2023. R4's service plan dated February 1, 2024, included services for daily cares, behavior support, med administration, transferring, and toileting. R4's record did not include an updated RN assessment. On February 14, 2024, at 8:50 a.m., Licensed Assisted Living Director (LALD)-H stated LPN's could contribute to gathering data for the assessment, but the assessment could not be locked or finalized by a LPN. LALD-H stated she was not aware resident assessments were not up to date. On February 14, 2024, 9:30 a.m., the Assisted Living Corporate Nurse Lead Registered Nurse (RN)-G stated she was not the facility RN but oversees facility clinical operations and the facility RNs. RN-G stated she was not aware assessments were not up to date until requested by the investigator. RN-G stated assessment should be completed by a RN every 90 days or with a change in condition. The licensee's Assessment-Schedule policy	01620		

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(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) COMPLETE DATE
01620	Continued From page 11 dated August, 26, 2021, indicated ongoing monitoring and reassessment should be completed at least every 90 days and completed by a RN. The change in condition assessment would be completed as indicated by a RN. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure appropriate care and services were provided based on the resident's needs and according to an up-to-date assessment and service plan subject to accepted health care standards, when a smoking assessment and safety interventions were not implemented for one of one resident (R4) reviewed. This had the potential to affect all residents residing in the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a	02310		

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	30675	A. BUILDING: _____ B. WING _____	C 02/13/2024

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02310	Continued From page 12 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's diagnoses included dementia, heart disease, chronic obstructive pulmonary disease, R4's service plan dated February 1, 2024, included services for daily cares, behavior support, medication administration, assistance with incontinent cares, reassurance checks, and assistance with transfers and ambulation. R4's Admission Vulnerable Adult/Individualized Abuse Prevention Plan (IAPP) dated August 22, 2022, indicated R4 was safe with smoking and included a goal that R4 would not suffer from injuries related to unsafe smoking or oxygen use. The assessment was completed by a licensed practical nurse (LPN). There was no evidence that an observation of R4 was completed at the time of the assessment. R4's vulnerability assessment was dated October 20, 2022, completed by a LPN, indicated R4 was safe smoking. R4's progress notes dated April 18, 2023, indicated in the past two weeks R4 had been smoking in the front entrance of the building and did not seem to remember she was not supposed to smoke in the building. The progress notes also indicated concern with R4's cognition and memory. R4's medical record lacked documentation a registered nurse (RN) was notified of R4 smoking in the front of the building. R4's medical record	02310		

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02310	Continued From page 13 was not updated to include a smoking assessment, or observation of R4 smoking to determine if R4 was safe to smoke independently, and R4's IAPP was not updated. R4's annual RN assessment dated August 16, 2023, indicated R4 was a current every day smoker. The assessment did not include a smoking assessment or documentation an observation of R4 smoking was completed at the time of the assessment. R4's progress note dated February 11, 2024, indicated staff were informed on February 9, 2024, that the Parlor door that R4 utilizes to go outside to smoke was not working and maintenance was informed of the issue. Staff told R4 to smoke in the front of the building until the door was fixed. On February 10, 2024, staff informed the LPN they noted a a strong smell of cigarette smoke coming from R4's bathroom. [LPN] told staff to remove the cigarettes and lighters and to only give R4 a cigarette when requested. The same day two of R4's peers alerted staff that R4 was smoking in the front entry way of the building and when staff went to the front of the building they could smell cigarette smoke. The note indicated staff will monitor and re-request maintenance to fix door. R4's medical record lacked documentation a registered nurse (RN) was notified of R4 smoking over the weekend. R4's medical record was not updated to include a smoking assessment, or observation of R4 smoking to determine if R4 was safe to smoke independently, and R4's IAPP was not updated. On February 13, 2024, the investigator observed R4 outside smoking. R4 put out her cigarette in a	02310		

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02310	Continued From page 14 trash receptacle that was located under an awning attached to the facility, located approximately three feet from the facility. The trash bin was filled with garbage. When R4 entered the facility, the investigator noticed burn holes on R4's coat. When questioned if she had burn holes on her coat, R4 stated, "Oh, I probably do." When questioned about putting the cigarette out in the trash R4 replied, "I make sure it is out before I put it in there." The investigator took a picture of the plastic trash receptacle under the facility awning. The picture showed the plastic garbage full of trash, with multiple cigarette butts on the top of the can. The plastic trash can had a small hole on the top of the can where cigarette butts were being discarded. On February 13, 2024, at 12:26 p.m., LPN-C stated she was notified over the weekend that R4 was smoking in the building. LPN-C stated she did not perform a smoking assessment after she was notified of this information. LPN-C stated the cigarette should be disposed of in a metal trash can and not a plastic trash can with trash in it. On February 13, 2024, at 12:32 p.m., LALD-H stated residents should not be smoking under the awning and should only be smoking at the designated smoking area. LALD-H also stated a cigarette should not be disposed of in the plastic garbage can underneath the awning. LALD-H picked up the plastic trash can, brought the whole can to the dumpster and threw it away. LALD-H stated she would re-educate the residents on the use of the designated smoking area. LALD-H stated if R4 had burn holes on clothing, that R4 should wear a smoking apron.	02310		

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02310	Continued From page 15 On February 13, at 1:08 p.m., ULP-B stated R4 was caught smoking in the front entry over the weekend and R4's cigarettes were taken away but on Monday (February 12, 2024) R4 was given her cigarettes back. ULP-B stated R4 fell asleep all the time in the hallway or in the dining room slumped over in her wheelchair. ULP-B stated R4 had burn holes in her coat and jeans. On February 13, 2024, at 2:40 p.m., ULP-I stated over the weekend there were two incidents where R4 was smoking in the building; one time in the front entry way and one time in her bathroom. ULP-I stated she told the RN about R4's burn holes in her clothes. ULP-I stated she didn't think R4 was safe with her cigarettes since R4 did not remember things well. ULP-I also stated R4 fell asleep easily in the hallway or dining room. On February 13, 2024, at 3:33 p.m., facility clinical supervisor registered nurse (RN)-J confirmed she completed a smoking assessment that afternoon and R4's assessment indicated the need for R4 to wear a smoking apron. RN-J observed R4 smoking and noted when R4 lit her cigarette, the lit cigarette hit R4 clothes since R4 hunched over. RN-J stated a smoking apron would protect R4 from burns. The investigator pointed out to RN-J that R4 was currently outside smoking independently without a smoking apron. RN-J was asked why R4 was outside smoking without the apron on that she was assessed for that day, and RN-J said they just got the apron at the facility and did not know R4 was outside smoking. RN-J then went outside to put the apron on R4. RN-J returned after R4 was done smoking and stated she would be training staff on R4's need to wear an apron when smoking. On February 14, 2024, 9:30 a.m., Assisted Living	02310		

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02310	Continued From page 16 Corporate Nurse Lead Registered Nurse (RN)-G stated assessments should be completed by a RN every 90 days or with a change in condition. RN-G stated the IAPP that included the smoking assessment should be completed yearly or with a change in condition. RN-G stated if a resident is smoking in the building a smoking assessment should be completed. The licensee's Resident Guide indicated the facility was smoke-free and prohibited smoking in any part of the building which applied to visitors, guests, and residents. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) Days .	02310		