

**Iowa Department of Inspections and Appeals  
Health Facilities Division  
Citation**

<b>Citation Number:</b> 8001				
		<b>Date:</b> February 6, 2020		
<b>Facility Name:</b> Iowa Veterans Home		<b>Survey Dates:</b> December 31, 2019-January 22, 2020		
<b>Facility Address/City/State/Zip</b>  1301 Summit Marshalltown, Iowa 50158		<b>MW</b>		
<b>Rule or Code Section</b>	<b>Nature of Violation</b>	<b>Class</b>	<b>Fine Amount</b>	<b>Correction date</b>

58.45(2)  +	58.45(2) Schedules of daily activities shall allow maximum flexibility for residents to exercise choice about what they will do and when they will do it. Residents' individual preferences regarding such things as menus, clothing, religious activities, friendships, activity programs, entertainment, sleeping and eating, also times to retire at night and arise in the morning shall be elicited and considered by the facility. (II)	II	\$500 (Held in Suspension)	UPON RECEIPT
58.41  +	481—58.41 (135C) <b>Residents' rights.</b> Each resident shall be encouraged and assisted throughout the resident's period of stay, to exercise rights as a resident and as a citizen and may voice grievances and recommend changes in policies and services to administrative staff or to outside representatives of the resident's choice, free from interference, coercion, discrimination, or reprisal. (II)			
58.39	481—58.39 (135C) <b>Residents' rights in general.</b> 58.39(1) Each facility shall ensure that policies and procedures are written and implemented which include, at a minimum, all of the following provisions (subrules 58.39(2) to 58.39(6)) and which govern all areas of service provided by the facility. These policies and procedures shall be available to staff, residents, their families or legal representatives and the public and shall be reviewed annually. (II)			

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	<p><b>FINDINGS INCLUDE:</b></p> <p>Based on clinical record review, observation, resident interview, family interview, staff interview, and facility to ensure each resident had the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The facility failed to treat each resident with respect and dignity and care for each residents in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.</p> <p>Resident #5 was moved to another unit within the facility away from friends and was instructed he could not leave the new unit without staff supervision. The facility also banned the resident from going to casinos or shopping trips. The resident could not manage his own money and if there were any infractions the resident would be discharged. The resident was fearful of being discharged. After the move to the new unit, Resident #5 was sleeping more and required an antidepressant to help with nicotine withdrawal and depression. The resident was tearful and expressed sadness of not being able to see his friends.</p> <p>Concerns were also identified for Residents #1, #7, #8, #9, #4, #12 as the facility restricted/and removed the rights of the residents to smoke as they have done since admission to the facility. Resident #14 was reprimanded after speaking his thoughts when visitors were in the building. The facility reported a census of 428.</p>			
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	<p>1. The annual Minimum Data Set (MDS) assessment dated 9/24/19 for Resident #5 identified an original admit date of 6/25/15. The MDS recorded a Brief Interview for Mental Status (BIMS) score of 15 without signs/symptoms of delirium. A score of 15 indicated intact cognition. The MDS recorded the resident displayed no behaviors during the 7 day look-back period. The MDS revealed the resident independent with transfer and locomotion on/off the unit. The MDS documented diagnoses that included nicotine dependence.</p> <p>The quarterly MDS assessment dated 12/25/19 continued to identify a BIMS score of 15 without signs/symptoms of delirium and no display of behaviors. The resident remained coded as independent for transfers and locomotion on the unit but documented as totally dependent upon 1 person for locomotion off the unit.</p> <p>The care Directives dated 1/13/20 informed staff the resident independent with transfers and locomotion on the unit with a manual wheelchair. Under locomotion off unit, the directives informed staff the resident to be assist of 1 person with manual wheelchair and his boundaries to be the unit. The staff directed to escort the resident for all off unit activities/appointment and were not to leave the resident unattended.</p> <p>The care plan problem area updated 9/27/19 identified the resident enjoyed having a job to earn additional spending money so he could go to the casino and shopping. The care</p>			
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	<p>plan directed staff to encourage ongoing involvement in the incentive therapy program.</p> <p>The care plan problem area updated 9/30/19 identified the resident preferred self-directed leisure time and would like to participate in facility sponsored activities of his choice. Activities such as unit meetings, special meals both on and off campus, shopping trips, and casino trips, combined with those activities that he independently planned in between; such as going to the casino on the shuttle and outings with family and be smoke free on those outings. The care plan directed staff to invite the resident to activities which coincided with his activity interests such as: casino trips, fishing, sporting events, meal outings, shopping trips, and tours.</p> <p>The goal evaluation dated 12/31/19 documented the resident goal processing. The resident satisfied with the activities he attended on and off the unit, adjusting to living on a new unit, and cooperative with the restrictions of smoking. The resident said he enjoyed going out for special meals and outing with the facility. The resident tended to spend most of his time in his room but did come out occasionally to participate in unit activities such as pet visits and going out to eat.</p> <p>The care plan problem area created 10/25/19 identified the resident had an addiction to nicotine and wanted to be smoke free. The measurable goal created 10/25/19 and updated 12/27/19 documented the resident would be smoke free and adhere to his smoking cessation plan in the next 90 days with next review date in 78 days on 3/31/20.</p> <p>On 10/25/19 the care plan directed staff to: provide the resident with smoking cessation agents to help his cravings; encourage the resident to attend the smoking cessation group or individual psychotherapy; provide with an escort</p>			
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	<p>when leaving grounds for activities/appointments to help monitor purchases; and provide the resident with a total funds restriction to help limit his access to money. The care plan intervention created 10/25/19 and discontinued 12/27/19 documented the resident transferred to a different building to help deter him from smoking or being around the smoke room.</p> <p>The goal evaluation dated 12/27/19 documented the resident had not smoked since transfer to KU5 (Ulery building unit 5) and Wellbutrin (antidepressant medication) started on 11/8/19 with the resident reporting it helped him with cravings.</p> <p>The Smoking Assessment signed 12/26/18 documented the following:          Question (Q) 1 - resident smoked          Q2 - resident alert          Q3 - resident physically capable of holding a cigarette, matches/lighter, and lighting and extinguishing own cigarette without assistance.          Q4 - resident able to extinguish a lit cigarette ash/cigarette which had fallen on his/her person and/or on others          Q5 - resident able to call for help if lit cigarette ash/cigarette fell on his/her person or on others          Q6 - resident able to move without assistance to designated smoking area          Q7 - resident had a past history of poor judgment regarding safety of himself or others          Q8 - check box left blank to indicate the resident did not have medical contraindications to smoking          Q9 - resident instructed in facility policy regarding safety of himself or others</p>			
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	<p>Q10 - resident signed the Resident Smoking Agreement and Smoker Release of Responsibility Form Q13 - Smoking Status based on Q1 thru Q10 = Unsupervised smoker. Comments - Resident without smoking incident on facility campus. Smoking incident occurred on 4/6/18 when resident smoked in a public bathroom without injury while on a REC (Recreational) trip for breakfast at a restaurant off facility property. The resident received education from REC staff and set up to no longer have smoking materials for trips but received materials when he returned to facility campus. The resident compliant since last facility incident on 8/30/18 where the resident had a strong odor of smoking, however, no evidence of inappropriate smoking found.</p> <p>The Smoking Assessment signed 2/28/19 documented identical information for questions Q1 thru Q13 as 12/26/18 assessment and the resident remained an Unsupervised smoker. The Comments section recorded security found evidence of smoking at the IT (Incentive Therapy) laundry location; ashes found, broken lit cigarette in trash can, and smell of smoke. Others in room not smokers and denied smoking. The resident denied at first but then said he did break his cigarette in half and threw it away. The resident didn't admit to not smoking, he just stated he didn't understand but would except his punishment anyway. Smoking assessment completed, resident appropriate with restrictions placed until 4/30/19.</p> <p>The Smoking Assessment signed 4/1/19 documented identical information for questions Q1 thru Q13 as 2/28/19 assessment and the resident remained an Unsupervised smoker. The Comments section recorded the resident</p>			
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	<p>continued on restriction until 4/13/19 due to resident purchasing cigarettes in the smoke room prior to REC trip. The current restriction of 2 cigarettes given to the resident at a time and the resident to check lighter back into staff upon returning to the floor. The resident's smoking practice remained appropriate upon assessment and reassessment to occur after 4/13/19.</p> <p>On 6/19/19 at 10:15 p.m. the Progress Notes documented the resident instructed on updated designated smoking areas and that oxygen equipment must be stored in appropriate area. The resident verbalized understanding that smoking outside of designated smoking areas would result in immediate removal of smoking privileges until reassess by the care team.</p> <p>The Smoking Assessment signed 6/20/19 documented identical information for questions Q1 thru Q13 as 4/1/19 assessment and the resident remained an Unsupervised smoker. The Comments section recorded the resident assessed, safe smoking practices at that time, and resident aware of new smoking restrictions.</p> <p>The Smoking Assessment signed 6/26/19 (however referred to actual date of 6/25/19) documented identical information for questions Q1 thru Q10 as 6/20/19 assessment but the resident changed on Q12 to a Supervised smoker. The Comments section recorded the resident assessed, safe smoking practices at that time, and resident aware of new smoking restrictions and consequences of unsafe smoking practices.</p>			
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	<p>The incident report categorized as type behavior dated 6/26/19 at 3:05 p.m. documented the resident seen smoking outside of Dack building main entrance according to a phone call received by Staff J, Registered Nurse (RN), from the switchboard operator. Per the operator, 2 phone calls received about Resident #5 smoking inappropriately. Resident #5 on a recreation trip and notified his cigarettes needed removed and he must return to his unit immediately for a follow-up to be done. Staff J documented she completed a smoking assessment, reviewed safety expectations with the resident, and all smoking materials would be removed with smoking restrictions put in place. To prevent re-occurrence, the resident would be on smoking restriction of 1 cigarette at a time with maximum of 6 cigarettes a day, smoking materials to be locked up, resident to obtain smoking material from staff and staff to get materials from the resident when he returned to unit, and recreation would check with resident prior to him leaving on trips that he did not have smoking materials. The plan to be put in place for 6 months.</p> <p>On 6/26/19 at 3:26 p.m. the Progress Note documented a call received regarding the resident being seen by 2 witnesses smoking by White Hill prior to REC (Recreation) trip. Call placed to switchboard to verify individuals that reported the incident. Call placed to staff who were on the trip with the resident, incident reported, cigarettes taken from resident's possession on the trip, and smoking materials to be given to licensed staff upon return of the resident. The IRCC (Interdisciplinary Resident Care Conference) team discussed and made plan of action to entail resident receiving a total of 6 cigarettes in a day's time, 1 at a time, lighter to be returned upon return of</p>			
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	<p>resident to unit, and restrictions to be put in place for 6 months.</p> <p>On 6/27/19 at 6:38 a.m. the Progress Note documented by Staff O, RN, recorded the smoking changes and incident on hold at that time due to needing to discuss specifics with witnesses; care plan on hold at that time until clarification received.</p> <p>At 1:18 p.m., Staff O documented calls made that morning to witnesses, a driver and security, of resident smoking in un-designated area on 6/27/19 (date likely documented in error as should have been 6/26/19), as well as spoke with Nursing Supervisor and Switchboard Operator whom made calls. All individuals shared the resident smoked and had reports of resident smoking at Chapel entrance. Resident seen at about 12:30 p.m. on 6/27/19 per facility driver. The resident questioned and voiced it was not him and he did not smoke outside of the designated area. The resident able to voice the appropriate places to smoke and the safety expectations for resident smoking; reviewed and signed. The Administrator of Nursing contacted for guidance and confirmation on witnessed activity of inappropriate smoking practice outside of the chapel doors at 12:32 p.m. on 6/27/19, which was not a designated area. Cigarette butt found on the ground underneath the bench outside of the chapel doors. The resident again questioned on activity that occurred with accusations of inappropriate smoking; resident again denied. Encouraged resident he was seen smoking in un-designated area and consequences would be all smoking materials removed from his possession (placed in treatment room), as well as educated resident on new smoking restrictions placed on afternoon of 6/27/19. Staff shadowed the resident down to outdoor designated smoking</p>			
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	<p>area and observed he could smoke safe. Staff and administration updated on smoking restrictions, as well as directives updated. Restriction would be in place for the next 6 months (12/27/19). Continue to monitor resident for adherence to smoking expectations contract, his smoking restrictions, and guidelines put in place to assist resident with better smoking practices.</p> <p>The Smoking Assessment signed 6/27/19 documented identical information for questions Q1 thru Q12 as 6/26/19 assessment and the resident remained a Supervised smoker. The Comments section recorded the resident assessed following violation of smoking expectations as he smoked in a non-designated smoking area. Restrictions put into place for 6 months. The resident signed and acknowledged the new smoking expectations. The resident assessed and practiced safe smoking in designated area. The resident aware of the new smoking restrictions and consequences of unsafe smoking practices.</p> <p>The smoking policy form #475-2082, dated as revised 6/19, titled Safety Expectations for Resident Smoking, signed by Resident #5 on 6/27/19 included the following:</p> <p>a. Smoking is not permitted by residents in any facility building, entrance, hallway, restroom, public area, or where oxygen is used or stored, except for the smoking rooms located as follows: Dack main floor, Malloy main floor, Heinz Hall first floor north lounge. All other units have been designated as completely non-smoking.</p> <p>b. Smoking is not permitted within 15 feet of any entryway to any building or within 30 feet of any air intake of any building, with the exception of Fox and Ulery, where there is no smoking outside of the buildings. Smoking is not</p>			
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	<p>permitted on the dining patio on the south side of the canteen.</p> <p>c. Any unsafe smoking incidents or violation of safety rules will be reported and evaluated by the unit team and/or the Safety Officer. Incidents or safety violations are subject to action steps that may lead to restrictions in the ability to keep cigarettes and lighters/matches with you up to and/or including discharge to a different facility.</p> <p>As of 6/27/19, the facility smoking policy did not require residents to store smoking materials with the facility.</p> <p>On 6/27/19 at 4:00 p.m., Staff M, Social Worker (SW), documented in the Progress Note he met with Resident #5 with Staff O to discuss the resident's smoking incident the day before where he was observed smoking outside the facility chapel doors while waiting to load the facility bus to go on a recreation fishing trip. In the meeting, Staff M asked the resident if he was aware of the changes in the smoking areas/policy and designated areas to smoke. Resident #5 able to verbalize the changes and identified the areas where smoking allowed. When asked about the incident from the day before, the resident denied smoking in that area. Staff M discussed the reasons for the changes in smoking policy due to the facility's most recent VA survey and to ensure resident safety. Resident #5 continued to deny smoking in the area. Smoking expectations reviewed with the resident and he was informed that they would continue to look into the incident. Following the initial meeting, Staff M and Staff O went to the area outside the facility chapel and able to find a discarded cigarette butt under the bench which matched the brand the resident smoked. It was also noted there were video surveillance camera in the area.</p>			
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	<p>Staff M and Staff O met with the Administrator of Nursing to discuss. The video surveillance footage reviewed and able to verify the resident smoked outside of the facility chapel area at approximately 12:32 p.m. the day before (12/26/19). They then met again with the resident to discuss the incident and able to show him a picture of him smoking. They informed Resident #5 that due to smoking in a non-smoking area and continued smoking violations over the past year, he would now be placed on a cigarette restriction of 1 cigarette at a time with a total of 6 cigarettes per day for the next 6 months. They also informed him that all smoking materials would be kept at the nurses station and he would return all smoking materials when he came back to the unit from smoking. Current smoking areas reviewed with the resident and he verbalized the areas back to Staff M and Staff O. Cigarettes and lighter in his possession removed from his room and taken to the unit nurses station.</p> <p>On 7/1/19 at 1:19 p.m. Staff M documented in the Progress Note the resident voiced he felt things going pretty well overall but he remained upset about the new smoking rules at the facility. Staff M noted the resident emotional and tearful when discussing the new regulations/rules. The resident stated since his recent smoking incident he felt like he had been labeled an outlaw and explained he felt staff watched him more because of his smoking. Staff M noted the resident had been compliant with his smoking restriction and generally kept to himself and did spend time off unit. The resident reported his mood as rotten related to the recent smoking changes, he did feel kind of depressed, and the mood assessment completed that day showed a score of 5 which was up from a zero in the previous quarter (zero indicated no signs/symptoms of depression). The resident</p>			
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	<p>endorsed a loss of interest/pleasure in doing things, felt down/depressed, trouble staying asleep due to right hip pain, felt tired, and felt bad about himself. Most of the mood triggers due to the smoking issue and change in facility smoking policy. Under Support Networks, Staff M documented the resident generally kept to himself but did socialize with staff on the unit and other residents in the facility smoking lounge. Under Restrictions the note included the resident restricted for 6 months due to repeated issues with smoking and would end on 1/1/20.</p> <p>On 7/1/19 at 9:40 p.m. the Progress Note documented the resident upset when he went to get cigarettes and told he had already had 6 cigarettes. The resident said he didn't believe he smoked 6 cigarettes but told they could only go by the sign out sheet and nothing could be done until 6:00 a.m. the next morning. The entry recorded the resident groaned under his breath and left the unit to go downstairs.</p> <p>On 7/3/19 at 4:19 p.m. the Progress Notes documented a unit staff person thought they seen Resident #5 in his room with 2 packs of cigarettes and reported to Staff M. Staff M met with the resident in his room to discuss the report and noted the resident went on a casino trip that day. The resident denied buying cigarettes at the casino and Staff M asked if he could search the resident's room/locked drawer. Resident #5 consented with no cigarettes found. Staff M further asked if he could look in the resident's bag on the back of his wheelchair then the resident admitted he had bought 2 packs of cigarettes from another resident in the smoke lounge and denied purchasing at the casino. Staff M reminded the resident he remained on a cigarette restriction of 1 cigarette at a time and that ALL smoking materials</p>			
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<b>Facility Name:</b> Iowa Veterans Home		<b>Survey Dates:</b> December 31, 2019-January 22, 2020		
<b>Facility Address/City/State/Zip</b>  1301 Summit Marshalltown, Iowa 50158		MW		
<b>Rule or Code Section</b>	<b>Nature of Violation</b>	<b>Class</b>	<b>Fine Amount</b>	<b>Correction date</b>

	<p>must be kept at the nurses station. The resident's name placed on the 2 packs removed from his room and placed in the treatment room with a note placed on the 24 hour report to remind staff to search resident's wheelchair bag for cigarettes upon return from smoking lounge.</p> <p>The incident report categorized as type behavior dated 7/7/19 at 10:00 a.m. documented staff found cigarettes and lighter in resident's wheelchair, a full pack of his brand of cigarettes in his possession, and he stated he received them from a resident in the smoke room who owed him a pack. Noted that on 7/6/19 the resident only requested 2 of his 6 cigarettes from staff for the day. Nursing Supervisor contacted and discussed intervention as resident on a restriction already. The NS (Nursing Supervisor) advised no smoking until the IRCC team could meet and discuss the situation, the resident informed, and nicotine product offered but declined.</p> <p>On 7/7/19 at 2:01 p.m. the Progress Note documented Resident #5 seen leaving the unit at 11:20 a.m., staff addressed him, and he stated he was going to lunch. The NS called to unit to report security intervened on resident attempting to enter the smoke room as the attendant aware of the resident's restrictions to smoking. Security counseled the resident and staff reminded him of no smoking restriction.</p> <p>The Smoking Assessment signed 7/7/19 documented identical information for questions Q1 thru Q6 and Q8 thru Q12 as 6/27/19 assessment but Q7 left blank to indicate the resident did not have a past history of poor judgement; the resident remained a Supervised smoker. The Comments</p>			
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	<p>section recorded the resident assessed following violation of smoking restrictions as found with smoking materials in his possession in his room in wheelchair. Current smoking restrictions listed only 6 cigarettes in a day, 1 at a time, as well as no smoking materials in resident's possession. Applied new restrictions of no smoking at that time to resident until the IRCC team could discuss and make new decision regarding resident's smoking. The resident aware of new smoking restrictions.</p> <p>As of 7/7/19, the facility smoking policy stated incidents would first be evaluated before action steps taken. However, staff restricted the resident from smoking prior to evaluation.</p> <p>On 7/8/19 at 3:46 p.m. the Progress Note documented the new intervention for the smoking incident on 7/7/19 the resident would obtain 1 cigarette/lighter at a time from the smoke room monitor as requested and to return lighter to smoke room monitor upon exiting the room.</p> <p>At 4:50 p.m. the notes recorded the resident received directive he was not to bum or purchase smoking materials from other residents.</p> <p>On 7/9/19 at 12:58 p.m. the Progress Note documented the attendant at the smoking room stated they observed the resident selling a full pack of cigarettes to other resident in smoke room. Resident on restriction of 1 cigarette at a time and seen smoking 1 after another in smoke room by staff that supervised the area.</p> <p>At 4:23 p.m., Staff M spoke to the resident in his room about being observed selling a pack of cigarettes and the resident denied as he only got 1 cigarette at a time. Staff M</p>			
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	<p>requested to search the resident's room and no cigarettes found. Staff M again reminded the resident of his current restriction and expectation that he comply.</p> <p>At 8:22 p.m. the notes documented security asked to look at the video footage from the camera in the Malloy smoke room between 12:00 p.m. and 12:30 p.m. to see if they could see the resident with a pack of cigarettes and any interaction with another resident selling the pack of cigarettes. Security stated at 12:15 p.m. he seen the resident get a cigarette and lighter from the smoking monitor, entered smoke room, and lit cigarette. Shortly after arriving in smoke room the resident spoke to another resident, pulled something out of his pocket, at first security could not identify object for sure, then resident turned the object and security identified it as a gold colored pack of cigarettes. Security then said he watched the exchange of money, resident giving peer the pack of cigarettes. The primary nurse and nursing supervisor again spoke with the resident and confronted him about this new information. Resident continued to deny he ever had a pack of cigarettes and did not sell anyone cigarettes. Told resident he was on video tape and he just shrugged and continued to deny. They discussed they were glad he smoked in the appropriate places safely but told the whole reason why restricted to 1 cigarette at a time with cigarettes kept with smoke monitor was to ensure he went to the correct area to smoke. Explained to the resident if he carried cigarettes on him, it was way more likely he could light up somewhere he shouldn't. They then firmly told the resident if he had another smoking incident of smoking somewhere he shouldn't it would be very hard to justify him being allowed to smoke anymore. They reinforced this saying he may have to move to another building where there was no</p>			
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	<p>smoking. They told the resident they didn't want to have to do that but he needed to comply with the smoking rules.</p> <p>On 8/15/19 Resident #5 signed another new smoking policy, form #475-2082, dated as revised 8/19 (1st version), titled Safety Expectations for Nursing Resident Smoking. The new smoking policy included no information related to a 3 strike system. The major change on the smoking policy included smoking no longer permitted anywhere outside of the buildings or on facility grounds.</p> <p>The incident report categorized as type Equipment/Environmental dated 8/26/19 at 6:30 p.m. documented Resident #5 observed by the smoke room monitor allowing ashes to drop on his clothing and brushing them onto the floor as well as purposefully ashing on the floor rather than using the ash tray. Licensed staff notified and directed not to give Resident #5 any more cigarettes that night. The resident stated they took his cup away from him so he ashed into ashtray most of the time if he could get to one but sometimes he couldn't get to the ash tray because of the wheelchairs and walkers blocking them. The report documented the resident was issued a strike for the incident and also monitored 3 times to ensure safety with ashing and told to wear a smoke guard at all times when smoking.</p> <p>The Smoking Assessment signed 8/27/19 documented identical information for questions Q1 thru Q6 and Q8 thru Q12 as 7/7/19 assessment but Q7 now checked to indicate the resident did have a past history of poor judgement; the resident remained a Supervised smoker. The Comments section recorded the resident assessed following violation of safe smoking when found not disposing of ashes</p>			
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	<p>appropriately having ashes on himself. A smoking guard added to the resident for safety and 1st strike applied to the resident. Resident aware of new smoking restrictions and educated on strike system as well as monitored smoking x3 cigarettes appropriately. New safety expectation signed by the resident.</p> <p>On 8/27/19 at 2:22 p.m. Resident #5 again signed the smoking policy, form #475-2082, dated as revised 8/19 (1st version), titled Safety Expectations for Nursing Resident Smoking. The form contained no documentation in relation to a 3 strike system.</p> <p>On 8/27/19 at 4:39 p.m. the Progress Note documented the staff met with the resident in his room to further discuss his current smoking restriction and to discuss the strike system in relation to smoking. The resident informed of the expectations when smoking in the smoking lounge and he would be receiving his first strike for his smoking incident the night before. Discussion of the implications of future incidents in regards to the strike system were discussed and a copy given to the resident.</p> <p>On 9/3/19, Resident #5 signed the smoking policy form #475-2082, dated as revised 8/19 (2nd version), and titled Safety Expectations for Nursing Resident Smoking. The major change in this revision the facility moved to only 3 smoke times for the day.</p> <p>The incident report categorized as type behavior dated 9/5/19 at 2:20 p.m. documented the resident observed to throw his cigarette into ashtray without extinguishing it first as the smoke room was closing. Upon observation of the</p>			
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	<p>ashtray, staff noted the previous 2 cigarettes had not been extinguished either. The action to prevent re-occurrence documented as the resident no longer had smoking privileges and staff to monitor the resident's room twice a day to ensure he had no smoking materials on him.</p> <p>On 9/8/19 at 3:42 p.m. the Progress Note documented by Staff O recorded staff brought her the resident's coat after staff removed from resident to give him a shower and happened to find 3/4 of a pack of cigarettes and a Meskwaki match book. Supervisor notified of violation and resident upset not understanding why smoking taken away. Reviewed with the resident the violation and he said he had nothing more to say. When asked if he had any other materials in his room he denied any other materials present. Smoking replacement product offered and he declined. Smoking guide updated in the smoke rooms and NDS (Nursing Services Director) aware; would continue to monitor for further attempts to smoke and redirect resident as needed.</p> <p>On 9/13/19 at 3:08 p.m., the Progress Note documented Security notified the unit at 1:30 p.m. they smelled cigarette smoke in the bathroom on the main floor with ashes noted in the toilet and Resident #5 in the bathroom; he denied smoking. Staff F and Staff J located the resident outside and spoke with him; he denied smoking but consented to a search. Staff F and Staff J found 1 pack of cigarettes and 1 lighter on him. Staff searched the resident's room where they found 3 packs of cigarettes in a Meskwaki bag; the resident went to the casino on 9/12/19. The resident continued to deny smoking until found on him and told in</p>			
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	<p>violation of smoking policy where he lost his smoking privileges the previous weekend. The resident aware cigarettes found in his room and he declined a nicotine replacement. The care plan updated to search the resident's room twice a day with cares.</p> <p>On 9/14/19 at 3:59 p.m. the Progress Note documented it was explained to the resident that due to his cigarette purchase on a prior outing, he would not be able to go on outing to Wal-Mart.</p> <p>On 9/26/19 at 8:42 a.m. the Progress Notes documented the resident's room searched while he finished up in the shower and the RTW found a red lighter in the pocket of the residents tan jacket he wore daily. No cigarettes or other smoking material found, lighter removed.</p> <p>The incident report categorized as type Equipment/Environmental Smoking dated 10/1/19 at 1:23 p.m. documented the resident observed in the courtyard outside of Malloy LRC (Malloy Leisure Resource Center) with an UNLIT cigarette. When asked what he was doing the resident tossed the cigarette away. The staff retrieved resident from the area and brought him back to the unit to discuss the incident. The resident's room searched with 1 pack of cigarettes found in the resident's coat pocket and 2 more packs found in a bag hanging behind the wheelchair with 1 lighter and empty book of matches. The resident denied having any further smoking materials. A final warning letter issued to the resident if further incidents occurred he would be discharged from the facility. The resident agreeable to start on the nicotine patch. Staff would</p>			
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	<p>continue to complete room searches as previously. The resident voiced understanding of his final warning.</p> <p>A letter dated 10/2/19 on facility letter head documented the following: The purpose of this letter is to inform you of your final notice pursuant to Iowa Administrative Code section 801-10.43 (35D) which states: The Commandant or designee shall administer and enforce all rules adopted by the commission, including rules of discipline and, subject to these rules, may immediately suspend the membership of and discharge any member from the facility for infraction of the rules when the commandant or designee determines that the health, safety, or welfare of the members of the facility is in immediate danger and other reasonable alternative have been exhausted.</p> <p>The administrative rules allow the facility to place your residency in probation status following a second offense relating to non-compliance with the facility rules and your treatment plan.</p> <p>On 6/19/19 you were given a copy of the updated smoking areas and verbalized understanding.</p> <p>On 6/26/19 it was reported you were seen smoking outside of the designated area. You denied smoking but were seen smoking in a non-smoking area on the surveillance camera. An intervention was put into place to have all smoking materials kept and issued by nursing staff to keep you safe.</p> <p>On 7/3/19 you were found with 2 packs of cigarettes in your room. You were reminded of your restriction and your cigarettes were removed.</p> <p>On 7/7/19 you were again found with cigarettes and a lighter in your room. Your smoking privileges were temporarily removed at that time.</p>			
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	<p>On 7/8/19 you were allowed to resume smoking but all of your smoking materials were to be stored with the smoke room monitor and issued to you one at a time.</p> <p>On 7/9/19 you were found giving cigarettes to another resident in the smoke room even though you were not to have any cigarettes in your possession. At this time you were told a further incident would result in you not smoking or being moved to a non-smoking unit.</p> <p>On 8/26/19 you were observed ashing your cigarette on yourself and the smoke room floor.</p> <p>On 8/27/19 you were issued a 1st strike, following the 8/26 incident per facility protocol.</p> <p>On 9/3/19 the new facility smoking policy and smoking times were reviewed with you. You agreed and signed the updated facility Safety Expectations for Resident Smoking.</p> <p>On 9/8/19 you were found with cigarettes on your person which violated your care plan and the facility Safety Expectations for Resident Smoking. At this time you were offered nicotine replacement and declined.</p> <p>On 9/13/19 you were found to have been smoking in the Malloy main men's bathroom and had 3 packs of cigarettes on your person. Your smoking privileges were removed at that time. You were again offered and declined nicotine replacement.</p> <p>On 10/1/19 you were observed smoking in the courtyard. Cigarettes were again found on your person and in your room. You did accept nicotine replacement when offered this time.</p> <p>The facility has many resources to assist you in smoking cessation including nicotine replacement products (patches, lozenges, or gum), prescription medications, a Smoking Cessation Group, a total funds restriction, or individual</p>			
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	<p>mental health services. Please give serious consideration to these resources.</p> <p>Please be aware having your residency placed on probation status is a very serious matter. Your continued residency at the facility is at risk. You are expected to abstain from smoking or having cigarettes or other smoking materials in your possession while you are a resident at the facility. If there should be a 3rd offense, I will initiate involuntary discharge proceedings.</p> <p>Please see me if you have questions or concerns, Sincerely, Commandant.</p> <p>On 10/2/19 at 5:29 p.m. the Progress Note documented the Commandant met with the resident to present him with a final notice letter as to notify him his residency at the facility considered to be probationary due to his repetitive refusal to adhere to the established smoking policy/rules and his established treatment plan.</p> <p>On 10/22/19 at 10:08 p.m. the Progress Note documented the resident returned from the casino. A search completed of his person and room with 2 and 1/2 packs of cigarettes and a lighter found under jackets in his recliner. The resident very concerned about his future as he felt as if the facility would kick him out. The resident tried to guilt trip and bribe staff with money to not tell anyone. The supervisors notified and cigarettes placed in the office. Resident became teary eyed when approached about the issue and spoke of surviving cancer and pretty sure his cancer back and would have nowhere to go if they kicked him out. The writer explained to the resident he was made aware of the consequences and he chose not to follow the smoking policies in place.</p>			
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	<p>On 10/23/19 at 9:00 a.m. Staff M wrote a late Progress Note for 10/22/19 at 9:20 a.m. Staff M documented he overheard the resident calling on the phone to make arrangements for the Meskwaki Casino shuttle to pick him up. Staff M reminded the resident of his probationary residency due to past violations of smoking rules and that returning to the facility with cigarettes would be a violation of this due to his loss of smoking privileges at the facility.</p> <p>On 10/24/19 at 5:08 p.m. the Progress Note documented care conference data worksheet completed and prepared for Ulery 5 transfer the next day pending provider orders.</p> <p>On 10/24/19 at 5:12 p.m. Staff M documented a Progress Note Summary that included the following: Resident went to Meskwaki Casino via shuttle on 10/22/19 and returned to the facility with 2 and 1/2 packs of cigarettes and a lighter. These were found by unit staff during a room search following his return from the casino on 10/22/19. This was noted to be a violation of his probationary status of residency letter that he received on 10/2/19. That afternoon at approximately 2:00 p.m. members of the RCC team met with facility administration members to discuss the incident further in regards to moving forward with discharge due to continued violations of the facility smoking policy or looking at additional restrictions and resources to assist resident in smoking cessation and maintaining his residency at the facility. After discussion it was agreed to have RCC members present the resident with 2 options: Proceed with discharge planning or present conditions/expectations to maintain his residency at the facility. The conditions were as follows:</p>			
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	<p>a. Move to Ulery 5 where he would need to remain on the unit, unless accompanied off unit with staff, while he was coping with the initial stages of smoking addiction cessation. This would be re-evaluated by his care team in the future.</p> <p>b. Voluntary ban from Meskwaki Casino.</p> <p>c. Voluntary total funds restriction.</p> <p>d. No casino or shopping trips with facility recreation.</p> <p>e. Participating in the smoking cessation support group and/or individual psychotherapy with mental health.</p> <p>It was noted if the resident agreed to these conditions/expectations they would be presented to him in a formal letter by the Commandant, Staff G, NSD, and Staff M on 10/25/19. Following the meeting the group met with the resident in his room to present the above options which were shared with the resident several times. Resident did share about purchasing cigarettes at the casino and making the decision to smoke. After an opportunity to ask questions about these options, resident decided to agree to the conditions/expectations as set forth to maintain his residency at the facility. The facility informed the resident the move to Ulery 5 would occur 10/25/19 and evening staff would assist him in packing his belongings. The resident's brother would be contacted to discuss which the resident initially did not want but after Staff M told the resident his brother would be contacted by the new team, the resident agreed it would be best for the information to come from Staff M.</p> <p>The facility letter dated 10/25/19, signed by Resident #5 and Staff G, documented the following:</p>			
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	<p>After repeated violations of the smoking policy, I, Resident #5, agree to the following in order to remain a resident at the facility:</p> <ul style="list-style-type: none"> <li>a. I will abstain from smoking or having cigarettes or other smoking materials in my possession.</li> <li>b. I will move today, 10/25/19, to an open room on Ulery 5. I will remain on the unit, unless accompanied off unit with staff, while coping with the early stages of smoking cessation. I understand this will be re-evaluated by my care team in the future.</li> <li>c. I will request a voluntary ban from Meskwaki Casino.</li> <li>d. I will request a voluntary total funds restriction. Any requests for funds will go through my social worker.</li> <li>e. I will only go on shopping trips with 1:1 staff or volunteer and will not go on Casino trips with facility recreation.</li> <li>f. I will participate in the smoking cessation support group and/or individual psychotherapy with mental health to assist me in successful smoking cessation.</li> </ul> <p>I acknowledge all of the above are being put into place to assist me with successful smoking cessation. I understand that my residency at the facility remains on probationary status and further violations of the smoking policy will result in my being discharged from the facility. My signature signifies agreement with the above.</p> <p>On 10/25/19 at 11:34 a.m. the Progress Note documented the resident transferred from M2N (Malloy 2nd floor North) to KU5 (Ulery unit 5) as part of smoking cessation plan. Resident boundaries updated to encourage resident to remain on the unit. Resident no longer able to smoke. At 3:52 p.m. Staff M documented he provided assistance with resident's transfer that a.m. and reminded the resident a total funds restriction required the resident to deposit all</p>			
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Facility Administrator

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Date

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Citation**

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	<p>monies into his facility account. The resident possessed 6 Styrofoam cups full of change from his bingo/casino winnings that amounted to \$134.92 which was taken to the facility cashier to be deposited.</p> <p>On 11/4/19 at 10:43 a.m. the Progress Note contained a psychologist assessment. The note recorded the resident alert and oriented x 3 (person, place, time) and reported a depressed mood. The resident appeared depressed and became tearful when discussing smoking and living on his new unit. The resident voiced he felt like a prisoner on his new unit and really upset about all of it. The resident reported in the past 6 months it had been all downhill. The resident processed recent consequences of unsafe smoking and endorsed depressed mood most days. The resident slept 12 to 15 hours per day since moving to the new unit, missed speaking with his old staff, and had no contact with his friends from his last unit. The resident reported attempting to quit smoking or to control his smoking with no success and he smoked 1 PPD (pack per day) for 65 years starting at the age of 10. The assessment documented the resident did have adequate decision making capacity regarding Decisions of Person (including Healthcare) and Decision of Finance.</p> <p>On 11/8/19 at 11:08 a.m. the Progress Note documented an order for bupropion (antidepressant medication also known as Wellbutrin) 100 mg (milligrams) tab, 1 and 1/2 tabs every day as the resident endorsed to mental health the smoking cessation extremely difficult despite nicotine patch.</p> <p>On 11/20/19 at 10:13 a.m. the Progress Note documented staff spoke to the resident about the cigarettes he had on the</p>			
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	<p>previous unit. Resident #5 expressed he wanted them back and staff reminded him that was not an option. Resident #5 told them to throw them away and the paperwork to discard completed. Resident #5 did not want to sign the voluntary ban from Meskwaki at that time.</p> <p>On 11/21/19 at 9:38 a.m. the Progress Note contained a psychologist assessment that documented the resident reported a depressed mood since last session. The resident felt incarcerated on his new unit and said he just tried to live with it. The resident desired to regain control of his money as he missed visiting the library and the canteen. The resident missed seeing his peers, staff from his last unit, and admitted he felt like a bad person. The resident became tearful when told he was not a bad person. The resident reported sleeping 12 to 15 hours per day and he slept to cope with depression. The resident said he started exercising recently and he processed prior unsafe smoking. The resident continued to experience cravings to use cigarettes.</p> <p>On 12/4/19 at 11:54 a.m. the Progress Note contained a psychologist assessment that documented the resident reported a euthymic (normal) mood since last session sleeping significantly less at 8 to 10 hours a day versus the initial 12 to 15 hours per day when he moved to the new unit. The resident denied depression or anxiety and recently went off the nicotine patch and reported no cravings or withdrawal symptoms. The resident missed staff from his old unit and stated Ulery a place to sleep as they didn't do anything over there; he thought they all slept. The resident desired to have the ability to leave the unit without supervision in the future and understood his current restrictions due to history of unsafe smoking. The resident</p>			
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	<p>stated they worried he would leave to the casino but felt he could leave the unit without smoking.</p> <p>Observation on 1/2/20 at 1:06 p.m. revealed the interior smoking room in the Malloy building located on the 1st floor unlocked. Several residents present in the room actively smoking with 3 staff members present to assist and monitor the area; Staff A, RN, Staff B, RN, and Staff C, RTW (Residential Treatment Worker, equivalent to a CNA [Certified Nurse Aide]). Staff C reported even if a resident went off facility property to somewhere like the casino where smoking allowed, and if the facility found out, the resident's smoking privileges would be revoked. Staff C stated that actual example happened to a resident who had resided on her unit, M2N, then moved to Ulery due to the casino issue. Staff C reported the resident to be Resident #5 and it was her understanding it was the only real reason Resident #5 moved to the Ulery building. Staff C commented the facility found out about Resident #5 when an off-duty staff member present at the casino seen the resident smoking. Staff C referred to the book on top of a cart and stated the book listed the residents who had their smoking privileges revoked. Staff C clarified the book used to reference the residents who had their smoking privileges revoked due to any infraction made against the new smoking policy.</p> <p>The book contained the following information: Resident #5, M2N - Not allowed to smoke</p> <p>On 1/6/20 at 3:44 p.m. the Administrator responded she developed a list of smoking incidents for why residents' privileges revoked and she wanted to explain her notes. The Administrator reported Resident #5 someone who was a</p>			
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	<p>struggle, very addicted, ashes on clothes, and did not put cigarettes out safely. The Administrator stated Resident #5 smoked in the bathroom in Malloy building and he knew if he had another incident they would have to talk about discharge planning. The Administrator commented the facility needed to come up with a plan for if another incident occurred so they discussed having Resident #5 move to the Ulery building as not many smokers there and a different group of residents. The Administrator reported Resident #5 really wanted to stay at the facility and not be discharged so he opted for therapy and moving. The Administrator stated now Resident #5 did not have any incidents of smoking where he had 2 in bathroom at Malloy building. The Administrator stated Resident #5 grateful to the team they did not move towards administrative discharge. The Administrator commented she felt it was a win-win for everyone.</p> <p>On 1/7/20 at 3:40 p.m. observation revealed Resident #5 in his room, TV on, room dark, and he did not respond to call of name. A CNA assigned on the unit entered and assisted the resident into his wheelchair from the bed for an interview. At 3:45 p.m. the CNA left the room and Resident #5 self-propelled his wheelchair to the bed to obtain the remote without difficulty and turned down the volume to the TV. Resident #5 responded he did not quit smoking on his own. Resident #5 said he took the nicotine patch as the facility insisted he had to take it along with a little pill; he did not know why and stated it occurred approximately 3 months prior. Resident #5 said they transferred him over to the Ulery building from the Malloy building; they did not tell him why they moved him but he knew he broke 1 of the facility rules. Resident #5 reported he left the premises with</p>			
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	<p>the facility to go to the casino and they caught him with cigarettes when he got back. Resident #5 could not recall the date but stated it occurred on a weekday. Resident #5 reported the very next day the facility transferred him to live in another building, Ulery. Resident #5 stated the facility found the cigarettes as they checked him down upon return and found the cigarettes on his person. Resident #5 commented he had no choice in the matter. Resident #5 reported Staff M, SW, informed him he was not allowed to go back over to the Malloy building. Resident #5 voiced he was separated from the guys at Malloy, his friends. Resident #5 said he felt not totally happy about it and Staff M told him he couldn't ever smoke again. Resident #5 stated it did not sit well with him as he was mad and sad he had no choice. Resident #5 responded he had not exhibited any behaviors that he knew of that would require a transfer to the Ulery building. Resident #5 acknowledged there were other times where he held cigarettes on his person when he was not supposed to and the facility had notified him of the changes to the smoking policies, but he felt the facility not very clear about the notifications. Resident #5 stated the night they first changed the smoking policies to not smoking on the premises it happened at night. Resident #5 reported the next morning he went down to smoke at 10:30 a.m. and they nabbed him at the Malloy doors. Resident #5 commented he did not realize it had been made a no smoking area. Resident #5 reported the Commandant had threatened him to have him leave the facility if he did not comply with the new program; he would be discharged. When asked if he felt a fear of retaliation, Resident #5 responded he did not know. Resident #5 stated that guy (Commandant) is not long for this place as he changes the rules on us frequently and is making waves. Resident #5</p>			
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	<p>responded he would have wanted to keep smoking and felt he hid the cigarettes obtained from the casino because of it. Resident #5 stated he had smoked for 66 years and been made to quit all of a sudden. Resident #5 stated he was not sure if the patch helped him or not and reported he had to take a little pill as well. Resident #5 responded he had no option to refuse the medication. Resident #5 clarified he felt it was okay to smoke at the casino as 1,000 other people at the casino smoked. Resident #5 stated he thought the facility had told them they could not smoke on any of the trips.</p> <p>Resident #5 exhibited signs of sadness related to his loss of smoking as evidenced by tears welling in his eyes with trembling chin when he responded he had smoked for 66 years and able only to verbalize it didn't feel great being moved to the Ulery building with the loss of privileges.</p> <p>In a follow-up interview on 1/21/20 at 2:52 p.m., the Administrator reported Resident #5 went thru a strike system and the facility did not feel the resident appropriate to live on a locked unit because he was very high functioning and he wouldn't want a locked unit. The Administrator stated they talked to Resident #5 about the risk to smoking and he would say he wasn't going to do it anymore. The Administrator said the team met with Administrator of Nursing instead of moving to discharge plan and moved the resident to the Ulery unit. The Administrator commented it would give Resident #5 a fresh start with a new team, not the same peer group, not as close to the same smoke group, and the facility wanted to present an option instead of discharge planning. The Administrator reported Resident #5 met with Staff M. The Administrator stated Staff M felt Resident #5 would be happy to stay there</p>			
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	<p>(Ulery) and it might be a successful plan referring to the letter on 10/25/19. The Administrator reported the letter on 10/25/19 presented to Resident #5 who was appreciative to have ability to stay at the facility. The Administrator reported Staff M said he would stay in touch with the Ulery team if Resident #5 wanted that. The Administrator commented the reports she got were the resident had no further incidents, he was doing very well, and happy not to seek other placement. The Administrator voiced the unit Resident #5 resided on not a locked unit. When asked about the letter stating the resident not allowed to leave the unit without staff escort, the Administrator responded only during early smoking cessation and it hadn't been that long since 10/25/19. The Administrator stated she would have to ask the team for further information. In response to why Resident #5 lost the ability to go to casino, the Administrator responded she believed it was a trigger for him to be around people who smoked, felt a goal to get past early cessation, and she believed it was not forever. When informed Resident #5 felt forced to sign the 10/25/19 letter under threat of discharge, the Administrator responded her understanding with Staff M when the letter presented to Resident #5 he would do better, so it was hard at the beginning but then the resident would be able to get involved with other people. The Administrator responded she was not aware of the documentation in the clinical record when Resident #5 first moved over to Ulery unit noting he slept 15 hours a day or know he got more depressed. The Administrator commented they were going to proceed with discharge as team felt he would continue to smoke, felt couldn't keep others safe, and they had several issues that were too high a risk with others. The Administrator stated they met with the resident several times</p>			
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	<p>and would move forward with discharge if he did not give up smoking. The Administrator stated the resident needed to move to Ulery unit to get the nicotine patch and start with plan were he could be more mobile. The Administrator said as she didn't keep meeting with each of those teams, she did not know all the information. The Administrator voiced she knew Resident #5 met with the psychologist and told from Staff M Resident #5 very pleased for going over there. The Administrator clarified she would not call telling a resident they could be discharged a threat but rather call it being honest about the consequences of not complying. The Administrator added, but they didn't get to involuntary discharge. The Administrator stated Staff M an excellent Social Worker who thought Resident #5 would do better with a new setting. The Administrator stated the facility was sitting under an IJ (Immediate Jeopardy) from the VA annual survey conducted in May/June 2019. The Administrator said the facility made lots of changes and based on the data they did not immediately go thru the changes; stated shocked when they got the data. The Administrator reported the facility used to just monitor smoking with RTWs who didn't know how to handle the smoking changes. The Administrator commented they tried to keep residents safe but they couldn't provide 1:1 on Resident #5. The Administrator said the facility responsible to keep residents safe.</p> <p>On 1/21/20 at 3:34 p.m. Staff M confirmed the 10/25/19 letter given to Resident #5. Staff M stated Resident #5 told he either did what it said in the letter or the facility would discharge him. Staff M said the letter what he was given by the Administration. Staff M stated he was the one who came up with the proposal and requested the meeting with</p>			
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	<p>Administration. Staff M reported Resident #5's reaction remorseful and he knew he had no options as Resident #5's brother ill and he had no other family. Staff M said basically Resident #5 with no options so Staff M advocated for him to move to Ulery building as the VA Administration was going to discharge him. Staff M stated he didn't think discharge would be good for Resident #5 as Staff M did not know where they would place him or where Resident #5 would go if they discharged him. Staff M said he asked if there could be any other options for Resident #5. Staff M reported the rules made for Resident #5 included the resident couldn't leave the unit and it would be determined on down the road if that would change or be modified. Staff M responded it was his personal opinion Resident #5's infractions of the smoking policy of possessing cigarettes did not rise to the level of safety risk to others to the point of needing discharged; but others said he couldn't smoke.</p> <p>2. The MDS assessment dated 10/23/19 for Resident #1 identified an original admit date of 1/29/13. The MDS recorded the resident with unclear speech, rarely made self-understood, but had the ability to understand others with clear comprehension. The MDS recorded the resident's memory for short and long term memory without signs/symptoms of delirium. The MDS revealed the resident independent without assistance for locomotion on/off the unit and the presence of functional limitation in range of motion on only 1 side of both upper and lower extremities. The MDS documented diagnoses that included aphasia (loss of ability to express speech), hemiplegia</p>			
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	<p>(weakness on 1 side of the body), depression, and PTSD (Post Traumatic Stress Disorder).</p> <p>The care Directives printed on 1/15/20 documented the resident self-propelled his manual wheelchair with his left foot and left hand. Under General Condition, the Directives instructed staff to encourage yes/no answers and use of language board due to the resident being aphasic.</p> <p>The care plan problem area updated 10/29/19 identified difficulty speaking and expressing himself due to effects of stroke in 2012.</p> <p>The care plan problem area updated 1/30/19 identified the resident enjoyed smoking even though it was not recommended with his health history and his family supportive of his wish to smoke. The interventions included to assess his smoking abilities when being monitored in the smoke room to monitor his ability to continue to smoke safely.</p> <p>On 2/27/19, the care plan updated to include the resident signed the Smoking Safety Expectations form annually.</p> <p>On 4/29/19 the care plan Goal Evaluations documented the resident did not have any unsafe smoking incidents during the quarter, he smoked in the Malloy smoke room or outside when the weather nice, and he demonstrated safe smoking techniques during the observed quarterly smoking assessment.</p> <p>On 7/28/19 the Goal Evaluation again documented the resident smoke safely in a supervised setting in Malloy building smoke room, no unsafe smoking incidents during the quarter, and family voiced upset over the new smoking changes after provided a misinterpreted statement that the facility going smoke free on 10/1/19. The family member</p>			
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	<p>felt smoking the only thing the resident had left to enjoy, the SW (Social Worker) gave appropriate information about the new smoking rules of supervised smoking indoors only. The care plan contained no other documentation to indicate the resident no longer allowed to smoke.</p> <p>The Smoking Assessment signed 4/29/19 documented the following:          Question (Q) 1 - resident smoked          Q2 - resident alert          Q3 - resident physically capable of holding a cigarette, matches/lighter, and lighting and extinguishing own cigarette without assistance.          Q4 - resident able to extinguish a lit cigarette ash/cigarette which had fallen on his/her person and/or on others          Q5 - resident able to call for help if lit cigarette ash/cigarette fell on his/her person or on others          Q6 - resident able to move without assistance to designated smoking area          Q7 - checkbox left blank to indicate the resident did not have a past history of poor judgment regarding safety of himself or others          Q8 - resident had medical contraindications to smoking          Q9 - resident instructed in facility policy regarding safety of himself or others          Q10 - resident signed the Resident Smoking Agreement and Smoker Release of Responsibility Form          Q13 - Smoking Status based on Q1 thru Q10 = Unsupervised smoker.          Comments - Resident smoked in Malloy smoke room or outside when nice. The resident with no incidents of unsafe smoking during the quarter and no concerns noted when observed. The resident not able to specifically yell help due</p>			
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	<p>to aphasia, however, could make verbal noises, wave arms, and get attention in that manner if needed. The resident smoked appropriately when observed for assessment.</p> <p>The Smoking Assessment signed 6/29/19 documented identical information for questions Q1 thru Q13 as 4/29/19 assessment and remained an Unsupervised smoker. The Comments section recorded the resident smoked in the Malloy smoke room, no incidents of unsafe smoking during the quarter, and no concerns noted when observed. The resident not able to specifically yell help due to aphasia, however, could make verbal noises, wave arms, and get attention in that manner if needed. The resident smoked appropriately when observed for assessment (lit, smoked, and extinguished in proper receptacle).</p> <p>The Safety Expectations for Nursing Resident Smoking policy revised 08/19 (2nd version) signed by the resident on 9/3/19, included documentation that any single incident of unsafe smoking, including any incident of unsupervised smoking or any activity that put other residents at risk, would result in immediate, permanent removal of smoking privileges.</p> <p>The Progress Note dated 9/3/19 at 5:01 p.m. documented Resident #1 confirmed he had a concern late that afternoon about smoking. Residents had been receiving education from facility leaders that the smoking policy changing and starting the next day to smoke rooms open only 3 times daily from 8:00 a.m. to 9 a.m.; 1:00 p.m. to 2:00 p.m.; and 6:00 p.m. to 7:00 p.m. Resident #1 looked very dejected about the news shaking his head no. Resident #1 affirmed his desire for his family member to be called. The family</p>			
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	<p>member felt strongly the residents who currently lived at the facility should be grand-fathered in and retain the ability to smoke. The facility informed the family member they had multiple smoking incidents in nursing level of care since their Immediate Jeopardy from the VA 6/19/19 but no documented infractions for Resident #1 noted. The family member frustrated with the VA, as they supported Veteran smoking during their service. The family member asked who she could contact regarding her concerns and given the Administrator's phone number. Both the family member and the resident informed smoking materials would be kept at the smoke room. The facility encouraged Resident #1 to cooperate with handing in cigarettes as a smoking violation could result in immediate/permanent loss of smoking.</p> <p>On 9/4/19 at 5:26 p.m., a late entry Progress Note for 9/3/19, recorded the resident provided a letter which he read and signed re: the expectations regarding smoking, the one strike program, 3 smoking times per day, and the collection of smoking materials that evening.</p> <p>On 9/12/19 at 9:14 a.m., the Progress Note recorded a smoking assessment note that at 8 to 9 a.m. the resident did not put cigarette out in ash tray and left the cigarette burning in tray and staff put the cigarette out. The unit RN notified of event, made aware cigarettes still in cart, and unit RN would remove resident cigarettes from the cart.</p> <p>At 1:20 p.m. the notes documented report received the resident didn't put out cigarette properly. Staff D, RN, wrote she spoke with and informed the resident to put cigarette out all the way before dropping it in smoking receptacle. The resident mumbled due to aphasia but part of</p>			
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	<p>message understood and resident said he always did. Staff D recorded she observed the resident smoking at 1:00 p.m. and resident did extinguish cigarette all the way but portion of ash smoldered in ashtray x 10 seconds before going out. Smoking room attendant reported the resident always extinguished cigarettes as he should.</p> <p>On 9/12/19 1:22 p.m. a Smoking Assessment completed by Staff D and noted the resident: a smoker; knew the designated areas; got to smoking areas independently; lit smoking material safely, independently; did not shake/tremor while smoking; could extinguish smoking materials completely in an appropriate receptacle; did not fall asleep while smoking; no past accidents/incidents with smoking materials; no restrictions in place; smoking care plan and interventions in place; and no incident occurred. The assessment recorded no, the safety expectations not reviewed or signed as the resident monitored and extinguished cigarette as he should, and the smoke room monitor reported resident always extinguished cigarettes appropriately.</p> <p>On 9/25/19 at 6:23 p.m. the Progress Note documented the family member visited and continued to be upset regarding changes in the facility smoking policy for Resident #1. The family member spoke with the Commandant about the anticipated announcement of facility becoming smoke free. The family member expressed she wished the facility could grandfather in folks that had been smoking in the facility and she was informed the facility would be going smoke free in 2020. The family member planned to begin looking for alternate placement for Resident #1.</p>			
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	<p>The Smoking Assessment signed 10/29/19 documented identical information for questions Q1 thru Q13 as 6/29/19 assessment and remained an Unsupervised smoker. The Comments section recorded the resident smoked in the Malloy smoke room, no incidents of unsafe smoking during the quarter, and no concerns noted when observed on 10/28/19. The resident monitored 3 times daily in Malloy smoking room per facility smoking policy.</p> <p>On 10/30/19 at 11:53 a.m. the Progress Note documented when Resident #1 at the smoke room he showed staff the name on his lighter for them to know who he was when he needed additional cigarette. The entry recorded smoking materials kept with smoke room cart and with Switchboard. The entry documented the family member considered placing Resident #1 outside of the facility with notice the facility most likely would become a smoke free facility in 2020. The family member educated smoking ceased at VA facilities nationwide on 10/1/19, but not at the facility. The family member disappointed the VA influenced the facility to restrict their smoking policy to only 3 times a day for an hour after meals in specified smoke room. Resident #1 provided no indication of interest in smoking cessation. Resident #1 indicated by show of fingers he smoked generally 4 cigarettes per hour during the designated smoke times.</p> <p>Review of the clinical record revealed as of 11/1/19, Resident #1 demonstrated no unsafe smoking violations and remained an unsupervised smoker per the smoking assessments.</p>			
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	<p>On 11/1/19 at 3:28 p.m. the Progress Note documented a letter from facility Administration shared with the resident that the facility would be smoke free as of 1/1/20. The resident signed acknowledgement aware of the offered supports available as outline in the letter and could work with his team and mental health to find a product or service that would be useful during difficult transition. Also aware any violation may result in Administrative Discharge; letter would also go out to his guardian.</p> <p>On 11/26/19 at 10:09 a.m., the Progress Note documented while staff assisted Resident #1 on the toilet, they noticed a burn hole in the resident's sweat pants. Staff found 1 by 1.5 cm (centimeter) burn to the resident's anterior right thigh. The family member made aware the resident's smoking privileges had been removed due to injury to self and resident aware of inability to continue to smoke.</p> <p>Observation on 1/2/20 at 1:06 p.m. revealed the interior smoking room in the Malloy building located on the 1st floor unlocked. Several residents present in the room actively smoking with 3 staff members present to assist and monitor the area; Staff A, RN, Staff B, RN, and Staff C, RTW. Staff C stood at a cart with drawers and a book on the top; the drawers contained each individual resident's smoking materials in separate baggies. The book contained the following information: Resident #1, lived on M4S (Malloy 4th floor South) - 11/26/19 no longer allowed to smoke. Observation revealed no smoke guards in use in the smoke room.</p>			
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	<p>On 1/8/20 at 4:03 p.m. an interview conducted with Resident #1's family member. The family member voiced they were not at all happy with the changes to the smoking policies. The family member reported smoking had been acceptable for 7 years then the facility pulled the rug out from under the resident. The family member stated a lot of guys smoked in the service and the facility had very adequate smoking rooms with one room in Dack remodeled the previous year. The family member stated most of those guys were Korean or Vietnam vets where the military drop shipped cigarettes to them, in 1996 legislation passed veteran homes to have smoking facilities built for these guys, and they never found where it was repealed. The family member stated they knew the facility had very adequate smoking facilities for these guys as they could not smell smoke outside the smoke room, it did not affect air quality around that hallway, and they had been down there a lot. The family member stated they felt the facility should have a least grand-fathered in the residents who smoked and commented they talked to the Commandant, nurses, Social Workers, and a couple letters to the congressional department. The family member stated they spoke to the Commandant when the facility first cut out the outside smoking areas. The family member said it was unfortunate as the guys would sit out back laughing and talking. The family member reported Resident #1 non-verbal and not involved in that but they seen other residents use it as a social happy hour. The family member reported after the facility knocked out the outside smoking areas, the facility then went to only 3 times a day smoke times, an hour after meals, and that was the only time residents allowed to smoke. The family member stated they visited with the Commandant in Resident #1's room. The family member</p>			
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	<p>reported the Commandant said his hands were tied as it was not his decision but rather the VA; made it sound as if the Federal VA making him do it and therefore how could the family member argue with that. The family member voiced they asked whose the VA other than the facility but the Commandant said it was out of his hands but he would pass concerns along. The family member stated letting Resident #1 smoke the only exercise he got as he couldn't go outside anymore. The family member said the resident used to go down every hour and half, have cigarette, then back to his room, but now just sat in his room. The family member reported they seen a change in the resident as he was much more morose since the facility took his cigarettes and they talked with him on how much he slowed down in the last couple months. The family member stated the resident lost interest and part of that due to not smoking. The family member said they could only get to the facility once a month so Resident #1 did not have a lot of outside company. The family member felt the burn from 11/26/19 a minor thing, not a big deal, but the facility made a big deal out of it. The family member reported the facility said it was a little hole in his pants, they told them to throw the pants away, and only a minor burn. The family member stated Resident #1 with difficulties in communicating but he said it was no big deal. The family member commented the resident on a lot of gabapentin (nerve pain med), thought he got drowsy, and dropped an ash or cigarette towards end of November. The family member stated the facility informed them there was absolutely no chance of re-assessment as he was in a 1 and done offense. The family member commented for a while the facility had neck to knee aprons when first started smoking regulations, but once cut down outside smoking and monitored in smoke room, all of sudden the apron</p>			
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	<p>things gone and if had problem they were done smoking. The family member stated they only seen the smoking protective apron when they asked, couldn't they put the smoke apron on. The family member stated she was told no by Staff D RN, it was a 1 and done policy. The family member commented the nursing staff at the facility amazing, she couldn't praise them enough, but their hands tied too as they had to go by the rules. The family member stated if Resident #1 chose to smoke, they would want him to smoke again as not smoking at this point not going to save his life and it was more about his poor quality of life and the only 1 choice he had left in life. The family member voiced they felt so sad the facility took away smoking from someone in his condition who had such limited quality with nothing to look forward to.</p> <p>On 1/9/20 at 11:20 a.m. observation revealed Resident #1 in his room with door closed, watching TV. Resident #1 sat in a wheelchair and able to answer some questions with yes/no endings. Resident #1 attempted to answer a few open ended questions, but mumbles unable to be understood. Did acknowledge that his family member okay to speak for him on the resident rights and smoking issues. Resident #1 responded yes he felt he would want to keep smoking if allowed, yes he burned himself, yes he had been wearing a smoke guard at the time, yes he had burned himself before, yes he lost his privileges as a result. Observation revealed Resident #1 in wheelchair with right arm flaccid and in strap/brace to wheelchair arm, right leg with sheepskin boot on.</p> <p>At 11:29 a.m., observation revealed Resident #1 self-propelled his wheelchair out of his room towards the</p>			
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	<p>commons area hallway with left arm and leg able to maneuver around corners without difficulty, independently.</p> <p>3. The MDS assessment dated 12/5/19 for Resident #7 identified an original admit date of 1/30/14 with a re-entry after hospitalization on 5/23/16. The MDS recorded a BIMS score of 15 without signs/symptoms of delirium. A score of 15 indicated intact cognition. The MDS revealed the resident transferred independently, independent with locomotion on the unit, and required the limited physical assistance of 1 person for locomotion off the unit. The MDS coded no impairments in functional limitation in range of motion and the resident used a walker and wheelchair. The MDS documented diagnoses that included nicotine dependence and chronic obstructive pulmonary disease (COPD). The MDS coded the use of oxygen while a resident in the facility.</p> <p>The care Directives dated 1/13/20 documented the resident independent with transfers and locomotion on/off the unit. The care plan problem area revised 9/12/19 identified the resident with extreme shortness of breath with any exertion. The care plan informed the resident wore oxygen and needed to take oxygen off his wheelchair before he smoked. The care plan directed staff to provide assistance to complete Activities of Daily Living (ADL) because of fatigue and extreme shortness of breath.</p> <p>The care plan problem area created 5/30/19 and changed 1/2/20, identified the resident with a history of behavioral disturbances related to cognitive impairments from alcohol dementia. The care plan informed the resident: received psychotropic medications for depression and to help him</p>			
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	<p>sleep; he preferred to stay close to his room for meals; left the unit to smoke and for appointments and activities; and had a history of smoking with O2 (oxygen) on prior to admission to the facility. The measurable goal created 5/30/19 and discontinued on 1/2/20 documented the resident would remain safe and free from harm while living on an open nursing unit and maintain smoking privileges until 1/1/20, then he would be smoke free until next review date. The goal evaluation dated 9/12/19 documented Resident #7 free from harm and continued to be able to smoke at the facility. The smoking schedule caused resident some distress since only allowed to smoke 3 times a day for one hour intervals but he had been compliant with education regarding safe smoking and desired to continue smoking at that time.</p> <p>The goal evaluation dated 12/12/19 documented Resident #7 safe and free from harm. The facility would be smoke free on 1/1/20 and the resident aware of resources available to him to help transition to non-smoking. Resident #7 preferred to smoke until 12/31/19 and would quit cold turkey on 1/1/20.</p> <p>On 1/2/20 the care plan goal changed to the resident would voice satisfaction with smoking cessation program through the next review date. The interventions included to provide the resident with PRN (as needed) nicotine lozenges and with education about additional smoking cessation aides. The staff instructed to contact the resident's PCP (Primary Care Physician) if the resident wished to try something in addition to nicotine lozenges.</p> <p>The Progress Note dated 6/12/19 at 2:52 p.m. documented the resident got about the unit and the facility in his manual wheelchair with no documentation of problems getting lost</p>			
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	<p>or difficulty returning to the unit. The resident had been good about removing oxygen prior to smoking, indicated he enjoyed smoking, and recognized how smoking compromised his respiratory status. The note recorded no restrictions in relation to smoking.</p> <p>The Smoking Assessment signed 6/13/19 documented the following:          Question (Q) 1 - resident smoked          Q2 - resident alert          Q3 - resident physically capable of holding a cigarette, matches/lighter, and lighting and extinguishing own cigarette without assistance.          Q4 - resident able to extinguish a lit cigarette ash/cigarette which had fallen on his/her person and/or on others          Q5 - resident able to call for help if lit cigarette ash/cigarette fell on his/her person or on others          Q6 - resident able to move without assistance to designated smoking area          Q7 - checkbox left blank to indicate the resident did not have a past history of poor judgment regarding safety of himself or others          Q8 - checkbox left blank to indicate the resident did not have medical contraindications to smoking          Q9 - resident instructed in facility policy regarding safety of himself or others          Q10 - resident signed the Resident Smoking Agreement and Smoker Release of Responsibility Form          Q11 - checked for non-smoker          Q13 - Smoking Status based on Q1 thru Q10 = Unsupervised smoker.          Comments - Resident #7 kept his smoking materials in his possession; wore oxygen that he removed per self and left at</p>			
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	<p>a safe distance; smoked outside when weather permitted; signed safety expectations for smoking on 6/12/19; and had no unsafe smoking incidents that quarter.</p> <p>The Progress Note dated 6/19/19 at 8:46 p.m. documented the resident instructed on updated designated smoking areas and that oxygen equipment must be stored in appropriate area. The resident verbalized understanding smoking outside of designated smoking areas would result in immediate removal of smoking privileges until reassessed by the care team.</p> <p>The Progress Note dated 6/25/19 at 11:44 a.m. documented a 60-day visit with the ARNP (Advanced Registered Nurse Practitioner). The entry recorded the resident continued to smoke despite repeated admonition to stop and the resident stated he only smoked 6 to 10 cigarettes per day.</p> <p>The Progress Note dated 8/15/19 at 9:43 a.m. documented new safety expectations for resident smoking reviewed with Resident #7. Resident #7 voiced understanding and denied having questions related to new form #475-2082.</p> <p>The smoking policy form #475-2082, dated as revised 8/19 (1st version), titled Safety Expectations for Nursing Resident Smoking, signed by Resident #7 on 8/15/19 included the following: All oxygen equipment must be turned off and removed to a distance of at least 10 feet from any smoking area. Smoking with oxygen on or oxygen on a person, will result in immediate removal of smoking privileges.</p>			
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	<p>The Progress Note dated 8/16/19 at 7:29 a.m. documented an RN Directive Update that all smoking materials would be kept with the smoke room monitor. The rationale recorded as safety related to continuous O2 use.</p> <p>At 7:52 a.m., Staff E, RN, documented new safety expectations regarding leaving smoking materials with monitor related to continuous O2 use. The resident stated someone told him about it the night before and took his cigarettes and lighter to the monitor. Resident #7 denied having any open cigarette pack or lighter on his person. Resident #7 stated he had about 4 cartons in his drawer and Staff E asked the resident to allow those cartons to be locked in the treatment room. Resident #7 declined and asked why. Staff E explained if cigarettes available it may be easier to smoke with O2 on but keeping all cigarettes with staff allowed smoking monitor to ensure O2 off prior to going into the smoke room. Resident #7 voiced understanding but continued to decline giving cartons to Staff E. Staff E left a message with the Nursing Supervisor (NS) and Nursing Services Director (NSD).</p> <p>At 1:56 p.m., Staff E documented Resident #7 spoke with Staff F, NS, and Staff G, NSD, and agreed to give them his cartons of cigarettes to keep locked in the treatment room. Staff would provide smoking monitor a pack as needed.</p> <p>On 8/25/19 at 1:58 p.m. the Progress Note, documented by Staff H, Licensed Practical Nurse (LPN), recorded Resident #7 in the smoke room reading a book. Staff H wrote they tried to educate Resident #7 about not having flammable things in the smoke room and the resident refused to give up his book. Staff H noted Resident #7 stated security told him he could have the book in there and refused to give it up</p>			
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Facility Administrator

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Date

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	<p>stating it was not him. Staff H wrote Resident #7 smoked with 1 hand and held his book in the other; smoking monitor called switch board to call supervisor.</p> <p>On 8/26/19 at 7:54 a.m., Staff I, RN/NS, recorded a late entry for 8/25/19 at 2:10 p.m. in the progress notes. The entry documented Staff I spoke with Resident #7 in the smoke room while he read a book but did not smoke at the time. Staff I noted the resident polite and reasonable in the conversation. Resident #7 understood why he couldn't have the book in the smoke room though he told Staff I 2 guys with badges told him he could. Resident #7 stated he was not the one with the problem, he knew what happened, and knew how to smoke and not start fires. Staff I agreed with Resident #7 but for the safety of all residents and to be consistent, all residents needed to abide. Staff I reminded Resident #7 of the sign placed outside the smoke room that the room for smoking and to let others into smoke; he could read elsewhere.</p> <p>The smoke policy form #475-2082, dated as revised 8/19 (2nd version), titled Safety Expectations for Nursing Resident Smoking, signed by Resident #7 on 9/3/19 included the following: All oxygen equipment must be turned off and placed in the designated oxygen storage area outside of the smoking rooms. Any single incident of unsafe smoking, including any incident of unsupervised smoking or any activity that puts other residents at risk, will result in immediate, permanent, removal of smoking privileges. An unsafe smoking incident may include, but is not limited to: violation of any of the above listed safety expectations;</p>			
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	<p>ashes or burn holes on clothing or chairs, burns on skin; falling asleep with a lit cigarette or dropping a lit cigarette on the floor; smoking with O2, taking O2 into the smoking area, or having stroller closer than 10 feet of smoking area - immediate loss of privileges; and any other activity determined to be unsafe and/or put other residents at risk.</p> <p>On 9/11/19 at 2:20 p.m., the Progress Note documented a quarterly Social Worker MDS assessment. The entry recorded the resident good about removing oxygen prior to smoking and had no unsafe smoking incidents. The note recorded the resident had to adapt to several new policies in regards to smoking at the facility the past quarter that included: adaption to no smoking outdoors; only able to smoke in Malloy smoke room for an hour after meals; smoking materials kept with the smoking monitor; and could no longer take reading materials or any paper products into the smoke room. The resident indicated he smoked 2 to 3 cigarettes in the hours he went to the smoke room and did not always go to the smoke room 3 times a day. The resident scored a zero on the depressive symptoms quarterly screen despite some initial upset with the smoking policy changes. Under Discharge Plan, documented the resident upset by some of the smoking policy changes at the facility that quarter and spoke about transferring to the Veterans Home in WI (Wisconsin) as smoking considered more liberal there. Resident #7 spoke to his number 1 contact about it but she was not supportive of discharge. The Social Worker educated them that residency would most likely have to be attained in WI for any such transfer. The Social Worker documented the resident seemed to be adjusting to the policy changes.</p>			
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	<p>On 9/12/19 at 9:58 a.m., a Smoking Assessment completed and noted the resident: a smoker; knew the designated areas; got to smoking areas independently; lit smoking material safely, independently; did not shake/tremor while smoking; could extinguish smoking materials completely in an appropriate receptacle; did not fall asleep while smoking; no past accidents/incidents with smoking materials; no restrictions in place, cigarettes administered to resident at the smoking room; smoking care plan and interventions in place; and no, the safety expectations not reviewed or signed as a quarter review.</p> <p>On 11/1/19 at 3:32 p.m., the Progress Note documented a letter from facility Administration shared with Resident #7 that the facility would be smoke free as of 1/1/20. Resident #7 signed acknowledgement that he was aware of the offered supports that were available as outlined in the letter and could work with his RCC team and mental health to find a product or service that would be useful during the difficult transition. Also Resident #7 aware any violation may result in Administrative Discharge. A letter would be going out to his Family/Representative.</p> <p>On 12/12/19 at 12:43 p.m., a Smoking Assessment completed with no changes from the 9/12/19 assessment. The assessment recorded the resident chose to smoke until 1/1/20 when the facility would go smoke free; and no, the safety expectations not reviewed or signed as it was a quarter review.</p> <p>Observation on 1/2/20 at 1:06 p.m. revealed the interior smoking room in the Malloy building located on the 1st floor unlocked. Several residents present in the room</p>			
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	<p>actively smoking with 3 staff members present to assist and monitor the area; Staff A, RN, Staff B, RN, and Staff C, RTW. Staff A reported the resident names of who currently smoked in the room during the observation which included Resident #7. Observation revealed Resident #7 smoked safely and independently in the smoke room without assistance.</p> <p>Staff C referred to the book on top of the cart and stated the book listed the residents who had their smoking privileges revoked. Staff C clarified the book used to reference the residents who had their smoking privileges revoked due to any infraction made against the new smoking policy. Staff C reported the system a 1 and done type that included anything such as: ashes falling off the end of a lit cigarette, dropping a lit cigarette, forgetting they couldn't smoke outside any longer, going to Heinz Hall outdoor area to smoke, going into the smoke room with an oxygen tank, or even going off property to smoke. Staff C responded the facility did have smoking guards/smoking aprons for residents to use so wondered why it would be an issue if ash fell off the end of a resident's cigarette and pointed to the epoxy type floor stating it wasn't like the floor would catch fire. Staff C reported if a resident lost their smoking privileges they were never allowed to get the privilege back. Staff C showed the cart contained Ziploc baggies which stored each individual residents' smoking materials who were allowed to still smoke; the drawer contained 13 individual marked bags. Staff C made several comments in regards to the residents and why they lost their smoking privileges as the surveyor flipped thru the book. Approximately 44 residents listed who had a picture crossed off to say no smoking allowed for those individuals. The reasons for the revoked privileges not documented on the</p>			
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	<p>pages. Staff C reported she thought the problem wasn't the residents but the staff not paying attention when monitoring as they were busy talking to each other rather than watching the residents. Staff C reported even if a resident went off facility property to somewhere like the casino where smoking allowed, if the facility found out, the resident's smoking privileges would be revoked. Staff A and Staff B confirmed the 1 and done policy with no second chances given.</p> <p>On 1/2/20 at 2:20 p.m., the Progress Notes documented a RN Directive Update written by Staff B. Staff B wrote Resident #7 removed as a smoker with the rationale for change documented as the resident violated the smoking policy and smoking privileges removed.</p> <p>At 2:35 p.m., Staff B documented during the 1 to 2 p.m. smoking session, the resident entered into the smoke room with his oxygen on. The on-call NS and NSD notified and smoking privileges removed from the resident per facility policy with the resident made aware of it.</p> <p>On 1/2/20 at 2:36 p.m., Staff B created an incident report type Equipment/Environmental Smoking. Staff B documented at 1:10 p.m. that day the resident entered into the Malloy smoke room with his oxygen stroller and oxygen on via nasal cannula. The report noted Resident #7 did not light his cigarette, turned around, went out of the smoke room, and removed his oxygen. The on-call NS notified and Resident #7's smoking privileges removed per facility policy.</p> <p>Review of the clinical record revealed no other incident reports related to smoking documented prior to 1/1/20.</p>			
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	<p>Observation on 1/2/20 at 2:45 p.m. revealed Staff B present outside of the Malloy smoking room. Request made to get copies of the book which listed smoking privileges and Staff B reported only security could unlock the smoking door and she already called them. Staff B reported she was waiting to update the book for Resident #7 who just had his smoking privileges revoked. In response to why, Staff B responded it was sad, but Resident #7 rolled his wheelchair into the smoking room at the 1:00 p.m. smoke break with an oxygen container on his wheelchair. Staff B reported they missed it while monitoring and therefore it was considered an infraction of the smoking policy and no exceptions allowed. Staff B confirmed that it was staff's responsibility to ensure a resident did not enter the smoking room with oxygen on, they missed seeing it, but the resident still responsible and privileges revoked. Staff B stated she called the supervisor, Staff G, who confirmed the privileges needed revoked. Staff B responded it was a permanent revocation and the resident did not get another chance to return to smoking in the future. Staff B crossed off the resident's name/picture in the book and wrote the resident not allowed to smoke.</p> <p>On 1/2/19 at 3:00 p.m. the Administrator of Nursing stated the book only a reference and not part of a resident's care plan. The Administrator of Nursing stated the book not used and not accurate, staff should refer to care plans. When surveyor informed the Administrator of Nursing staff utilized the book during the smoking observations conducted from 1:00 p.m. to 2:00 p.m. that day, she responded the bags in the cart listed whether or not a resident needed a smoking apron or used a pipe and if a resident had no smoking materials available in the cart, then</p>			
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	<p>not allowed to smoke. Surveyor went thru approximately 10 residents in the book listed as no smoking and the Administrator of Nursing responded the information accurate for the residents listed as having smoking privileges revoked. In response to if a full smoking assessment completed for residents at the time nursing supervisors revoked smoking privileges, the Administrator of Nursing responded no, there wouldn't be full smoking assessments as their smoking policy did not require one. The Administrator of Nursing said the decision to revoke based on infractions/incidents that occurred while smoking and residents knew that well as they were informed.</p> <p>On 1/2/20 at 3:47 p.m. Staff B documented she updated the bedside care plan placed in the resident's room. Resident #7 talked to the NSD per his request. Staff B spoke with the resident and he felt at that time all he needed was PRN (as needed) nicotine lozenges as he quit in the past without anything. Staff B encouraged the resident to inform staff if he needed something more than the nicotine lozenges.</p> <p>On 1/2/20 at 3:55 p.m., Staff G, NSD, documented she met at 3:30 p.m. with Resident #7 per his request regarding removal of his smoking privileges due to him entering the smoke room with his oxygen on earlier that afternoon. Resident #7 stated, well he didn't know if it would help but he thought he would try, when explaining why he requested to speak with her. Staff G confirmed the facility had a zero tolerance for unsafe smoking practices and that the immediate removal of his privileges was necessary. Resident #7 explained he was distracted when he went in the smoke room as he was conversing with a couple people prior to entering. Staff G provided active listening and</p>			
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	<p>empathy for the loss of his privileges and reminded him they would support whichever cessation plan he desired. Resident #7 voiced he wasn't worried too much about quitting as he had done it before, however, he just wasn't ready to quit abruptly. Resident #7 smiling and friendly during the interaction and thanked Staff G for the visit. Details of conversations relayed to someone who would assist the resident in developing a cessation plan.</p> <p>On 1/2/20 at 4:19 p.m., Staff A wrote a late entry to document that during the 1 to 2 p.m. smoking session, Resident #7 entered Malloy smoke room with portable O2 stroller and O2 on. Staff A noticed O2 at the same time as the resident did; the resident had NOT lit his cigarette yet. Resident #7 immediately left the smoke room, O2 on at 2 liters. Staff A notified #620 (NS), Staff G, and DON (Director of Nursing) with smoking privileges removed from the resident per facility policy. Staff A provided the resident education regarding the incident and removal of smoking privileges and 1:1 (one to one) time spent with the resident. Resident #7 calm and cooperative and reported it was his fault as distracted with labeling his new carton of cigarettes just purchased prior to entering smoke room. Staff A educated the resident his cigarettes could be donated or given to family. Resident #7 reported he would give the cigarettes to his daughter. Resident #7 asked who he could speak to about the smoking policy and information provided.</p> <p>Observation on 1/9/20 at 10:55 a.m. revealed Resident #7 sat in his wheelchair in his room. Resident #7 able to move about freely in his room to adjust volume on the TV and accepted a package of clean socks from a laundry staff</p>			
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	<p>member who passed by. Resident #7 responded he had smoked all his life. Resident #7 stated the facility went from a smoking facility to a non-smoking facility with only smoke rooms, monitors on the outside of the rooms, and cut down to smoke times of 3 times a day. Resident #7 responded the facility said the change due to way the law was so the VA changed up the way they did smoking. When asked if familiar with 1 strike rule, Resident #7 stated the facility made up their own rules as they went. Resident #7 said he used to read in the smoke room, that got taken away, then Kleenex taken away, and just 1 thing after the other taken from the residents. Resident #7 commented the facility just seemed to throw something against the wall to see if it stuck. Resident #7 reported he lost his smoking privileges due to entering the smoke room with oxygen on. Resident #7 commented that was what the monitors were supposed to do, make sure a resident safe to smoke but they didn't notice it, he realized it himself. Resident #7 stated he entered the smoke room, realized he forgot to remove his oxygen, had NOT lit his cigarette yet, immediately went back out of the room, and informed the staff he had forgot to take off his oxygen. Resident #7 reported he then lost his privilege to smoke because of the incident. Resident #7 stated his daughter had brought him a new carton of cigarettes and as they marked the cigarettes he got distracted. Resident #7 voiced the gal, Staff B, who monitored that day told him and she cried saying she was sorry. Resident #7 stated he spoke to Staff G the supervisor who said the same thing, the way he did it he had to lose his privilege. Resident #7 stated he felt he had no recourse and no one to turn to. Resident #7 responded he did fear retaliation a bit with the way the facility treated people over the least little thing when they lost privileges or sent a</p>			
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	<p>resident to Ulery building; Resident #7 stated he knew of other residents sent to the Ulery building due to rule violations. Resident #7 reported the facility offered him the choice of a smoking patch or throat lozenges and he tried the lozenges as he did not like the patch. Resident #7 responded since quitting smoking, he remained a bit jumpy. Resident #7 reported before the smoking policy changes, he smoked approximately 10 cigarettes a day and did not feel he was a heavy smoker. Then when cut back to the 3 smoke times per day, smoked approximately 6 cigarettes a day. Resident #7 responded had the facility not taken away his privilege of smoking, he would still want to smoke. Resident #7 said he enjoyed it and although his daughters didn't like it, they seen he enjoyed it so they tried to advocate for his ability to smoke. Resident #7 responded he hadn't been threatened with discharge if he didn't follow the facility smoking plan but he had heard of other residents who were threatened if they didn't go along with the program, they'd be discharged. Resident #7 commented another thing was a guy used to buy his cigarettes from the casino but then told he could no longer buy Resident #7's cigarettes from there but rather only from Hy-Vee grocery store. Resident #7 voiced the facility said it was the only place they would order cigarettes from and the price way higher there than the casino. Resident #7 said he would also like to have the ability to smoke outside. Resident #7 explained the smoke room 1 small room and used to be fine with residents taking turns to go in and out, however, once the facility changed to 3 times a day the room too smoky as guys chained smoked 2, 3, or more cigarettes at a time due to being limited. Resident #7 said all the residents would rather smoke outside when the weather decent and it was a lot easier on the lungs. Resident #7 stated it was the first</p>			
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	<p>time he had ever forgotten to take off his oxygen. Resident #7 stated the monitors were supposed to make sure the residents safe to smoke and they didn't see anything. Resident #7 stated the monitors had no problem taking his book at times so why not his oxygen? Resident #7 again commented he never lit the cigarette or did anything prior to noticing he forgot to take off his oxygen other than just entering the smoke room; that was it. Resident #7 reported the facility knew his daughter and he had spoken to a Senator on 12/14/19 as the Senator asked to speak to them in front of the Commandant and they went to a room. Resident #7 said it was after that when he lost his smoking privileges and he felt it could have been retaliation. Resident #7 commented his daughter did not know yet he lost his smoking privileges and he did not yet want to tell her. Resident #7 said he only got 1 cigarette out of the new carton his daughter had purchased, the facility took possession of the cigarettes, and he denied being reimbursed for the cigarettes. Resident #7 stated he usually had a routine when he went to smoke taking off oxygen, handing in his book, and that day different in that they were busy marking his new carton of cigarettes and he just wasn't thinking when he entered the room.</p> <p>4. The MDS assessment dated 11/5/19 for Resident #14 identified the resident with clear speech and ability to make self-understood as well as understood others with clear comprehension. The MDS recorded a BIMS score of 15 without signs/symptoms of delirium. The MDS coded the presence of delusions but no other behaviors. The MDS revealed the resident independent with transfers and</p>			
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	<p>locomotion on/off the unit. The MDS documented diagnoses that included schizophrenia, PTSD, and nicotine dependence with chewing tobacco.</p> <p>The care Directives dated 1/13/20 documented under General Condition the resident no longer using tobacco as of 1/7/20 and if seen chewing tobacco, staff to notify Licensed Staff to ensure the resident not using while on a nicotine patch. Under Negative Behaviors, the Directives recorded the resident could be accusatory and made false accusations at times.</p> <p>The care plan problem area dated 2/1/19 identified the resident lived with schizophrenia and sometimes felt others targeted and talked about him. The resident easily affected by what others said to him and took medication to help him cope with his thoughts and emotions that made him anxious and depressed. The care plan directed staff to assist the resident in identifying and developing anxiety-reducing skills such as relaxation, deep breathing, positive visualization, reassuring self-statements, and others. Staff directed to maintain a calm manner while interacting with the resident. The care plan goal evaluation dated 11/12/19 informed staff the resident continued to have delusions about having many children and needing to find them; the delusions remained as fixed delusions (refers to the strength of belief where a person is certain and not persuaded by any arguments to the contrary) and would become upset when challenged regarding those beliefs.</p> <p>The care plan did not address the resident's use of smokeless/chewing tobacco.</p>			
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	<p>On 12/2/19 at 3:19 p.m. the Progress Note documented the resident started chewing again on that day after quitting 5 months prior.</p> <p>On 12/13/19 at 7:51 a.m. the Progress Note documented by Staff F, NS, recorded she received a call that Resident #14 talked to other residents telling them the Commandant getting fired the next day and staff and residents would be able to continue to smoke after 1/1/20. Staff F wrote she stopped the resident and spoke to him in private on the effects of spreading rumors and how he didn't know any of that to be true. Staff F recorded Resident #14 stated his friend Resident #6 told him it was going to happen. Staff F encouraged Resident #14 to share only factual information as spreading rumors that may or may not be true would only upset other residents. Resident #14 voiced understanding and stated he would only share factual information with residents from now on.</p> <p>On 12/15/19 at 11:13 a.m., Staff J, RN, documented a late entry for 12/14/19 without a reference time in the Progress Notes. Staff J wrote Resident #14 down by the smoke room the day before (12/14/19) to hand Staff J his smokeless tobacco as Staff J monitored the smoke room. Staff J questioned Resident #14 why he gave her the tobacco and Resident #14 stated he was told by Staff K, Certified Medication Aide (CMA), he needed to have it in the cart by the smoke room and only use in smoke room. Staff J documented she told Resident #14 she would not debate the issue as Resident #14's tone loud and comments negative. Resident #14 then entered the smoke room with his tobacco and he did not usually go to the smoke room. When Resident #14 left the smoke room he went to restroom on</p>			
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	<p>the main floor then returned to hang around outside the smoke room. Staff J recorded a Senator present with Administration talking with several smokers outside the smoke room and Resident #14 spoke up to the Senator complaining about administration. Staff J wrote Resident #14 then returned to the unit.</p> <p>Staff J recorded on Sunday, 12/15/19 without a time reference, Resident #14 came to her that morning and informed her the smoke monitor wanted some clarification on his smokeless tobacco. Staff J informed Resident #14 he did not need to use the tobacco down in the smoke room, he should just use in his room. When questioned who told him that, Resident #14 responded a woman who was not the usual staff. Staff J informed Resident #14 he did not appear to be in a positive mood the day before so she did not want to draw attention to everyone else down on main floor. Staff J questioned Resident #14 why he was so upset and he responded he wanted to make sure the Senator knew administration lying. Staff J informed Resident #14 that a discussion with Staff J would have been more appropriate than causing a scene down by the smoke room. Resident #14 stated he was just upset and he didn't have any more smokeless tobacco but it was in the cart. Staff J informed Resident #14 he would have to wait until 1:00 p.m. for her to retrieve his chew from the cart downstairs. Staff J informed Resident #14 he should make sure his facts are correct before he made statements that may not be true.</p> <p>On 12/15/19 at 11:17 a.m., Staff K wrote a late entry for 12/14/19 without a time of reference in the Progress Notes. Staff K documented Resident #14 went up to the med cart for noon meds. Staff K recorded Staff L, RTW, seen the resident put dip of chew in his mouth and told him she didn't</p>			
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	<p>think he could chew there, just the smoke room. Resident #14 started yelling, oh yes he could chew wherever he wanted to. Staff K asked Resident #14 to please take his meds which he did without problem then wheeled out of common area yelling, he could do whatever he wanted to. Staff K recorded Staff L then called the supervisor and asked about the policy for chew and when she got off the phone reported the supervisor said he could chew anywhere.</p> <p>On 12/16/19 at 10:46 a.m. the Progress Note recorded an RN Directive Update under General Precautions, new Directive on smokeless tobacco (chewing), verification resident may chew anywhere on/off facility grounds.</p> <p>On 12/16/19 at 4:16 p.m., the Progress Note documented by Staff M, SW, recorded a letter provided to Resident #14 from facility administration notifying him the current smoking protocol would continue beyond 1/1/20; provided letter as the resident continued to use chewing tobacco.</p> <p>On 1/3/20 at 8:06 a.m., a late entry Progress Note created for 12/31/19 at 4:20 p.m. The entry recorded the facility psychiatrist responded to the resident's request for more amantadine (antiviral medication used to treat influenza type A and also Parkinson's type symptoms) to help decrease tremors and the psychiatrist responded with no change at that time due to potential side effects of psychosis but recommended the resident stop tobacco use as it could affect the drug levels of his medication. Resident #14 updated on 1/3/20 at 7:45 a.m. and the resident reported he would stop chewing after his 5 cans were gone. Resident #14 did not agree chewing tobacco could impact his drug metabolism and the nurse discussed that all nicotine products could do</p>			
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	<p>that. The note documented the resident in wheelchair at that time with mild hand tremors, no head tremors.</p> <p>On 1/7/20 at 3:18 p.m. the Progress Note documented the resident requested nicotine patch as he was trying to quit chewing tobacco as all 5 cans of chew gone and he would not be buying anymore.</p> <p>In an interview on 1/15/20 at 2:43 p.m. Staff K recalled working the weekend of 12/14/19 and 12/15/19. Staff K said their weekends very busy and it did not dawn on her until she was home she needed to do late entry regarding what happened on 12/14/19 with Resident #14. Staff K stated sometimes Resident #14 had delusions and she wanted to make sure the events were clear on what was said. Staff K denied anyone asking her to enter a late entry in the clinical record on 12/15/19, she alone thought to enter the information. Staff K reported while she prepared medication, Staff L seen Resident #14 grab a chew can and Staff L said she didn't think he could chew anywhere. Staff K said she just asked Resident #14 to please take his medications. Staff K stated Staff L then called the supervisor who said the resident could chew anywhere. Staff K responded no one took the resident's chew, the conversation occurred right in front of the nurses station, she was not sure but the time would have to be around lunch time, and not sure before or after lunch. Staff K reported Resident #14 upset, sometimes their pool staff didn't understand Resident #14, and she said just take your meds. Staff K stated she tried to diffuse the situation and Resident #14 took his meds and left. Staff K said the only thing she heard other than that was Resident #14 went downstairs and told someone he could only chew in the smoke room and</p>			
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	<p>that was not correct but he had already left. Staff K clarified it was after the resident went downstairs that Staff L called the supervisor who called back right away to clarify he could chew wherever he wanted. Staff K commented Resident #14 did not come back the rest of her shift for her to pull him aside and explain the policy.</p> <p>In an interview on 1/16/20 at 8:40 a.m. Staff J reported she worked for 22 years at the facility and her title Nurse Clinical; worked usually from 6:00 a.m. to 4:00 p.m. Staff J said she was very familiar with Resident #14. Staff J responded Resident #14 chewed off and on for the approximately 2 years while he lived at the facility. In response to what the smoking policy said on chewing tobacco, Staff J stated from what she understood, as long as the smokeless tobacco locked up in a resident's room then allowed to keep it themselves. Staff J commented the smoking policies had changed several times and it was hard to keep up with the changes. Staff J recalled working on 12/14/19 and assigned to the licensed cart but also responsible for monitoring the smoke room. Staff J recalled an incident occurred with Resident #14 revolving around whether or not he could hold his chewing tobacco on is person but stated she was not up on the unit/floor at the time as she was monitoring the smoke room. Staff J reported Resident #14 went down to the smoke room and said to her he had to use his chewing tobacco in the smoke room. Staff J commented knowing Resident #14 and his capability to make a scene, she just let him go into the smoke room. Staff J stated she was puzzled and did not know until she was up on the unit about the incident. Staff J reported someone who normally worked the other end of the unit, Staff L, told the resident to go downstairs to chew. Staff J</p>			
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	<p>stated Resident #14 started an argument and why he went down to the room. Staff J responded she did not know why a resident wouldn't be allowed into the smoke room if they didn't smoke; she thought it would be allowed. Staff J commented Resident #14 was a big friend of Resident #6 who had been adamant about smoking rights. Staff J reported a Senator and another politician guy present by the smoke room. Staff J stated she heard Resident #14 say to a Senator he believed the facility locking residents up in the secured units. Staff J commented she chose not to intervene. When asked why she felt she would have needed to intervene, Staff J responded Resident #14 had mental health issues with abilities to get irate, loud, and it was downstairs in front of everyone. Staff J said Resident #14 came up and asked so she asked who told him that. After reviewing her documented late entry dated 12/15/19 at 11:13 a.m., Staff J responded no one asked her to create the late entry, she just knew she needed to put it in the record. Staff J stated the progress note a late entry because on 12/14/19 she left at 2:30 p.m. and it had been a busy day. Staff J commented it was on her for not getting the documentation in the clinical record timely on 12/14/19 but she knew it needed to be documented to record Resident #14's behaviors. When asked why the incident viewed as Resident #14 having a behavior, Staff J responded because Resident #14 had a lot of ups and downs. Staff J responded she told Resident #14, per her documented progress notes, he needed to watch what he was saying as Resident #14 had a tendency to say things that were not true and she did not think it was necessary for Resident #14 to say anything. In response to asking if Resident #14's rights to free speech different from other residents, Staff J said no. Staff J commented if Resident #14 had a concern he should have</p>			
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	<p>spoken to her first and not made a scene downstairs. Staff J stated she was not debating Resident #14's right to speak but rather saying he should have talked to her first as concerned therapeutic to his mental health status. Staff J said she felt it was part of her job to be therapeutic. Staff J stated had Resident #14 talked to her first, it would have made sense. Staff J responded she had no knowledge of anyone taking Resident #14's smokeless tobacco/chew. Staff J said, that's another thing, then Resident #14 wanted his chew back on Sunday, 12/15/19. Staff J reported she told Resident #14 he couldn't get it back until 2:00 p.m. as it was locked up in the smoking materials cart located in the locked smoke room. Staff J responded the process for unlocking the smoke room required staff to call security to have them unlock the room. Staff J said staff called the switchboard who then contacted security who were available 24/7. Staff J acknowledged her late entry progress note lacked documentation of times for the interactions with Resident #14. Staff J clarified the incident at the smoke room occurred on 12/14/19 at approximately 1:00 p.m. Staff J clarified she locked Resident #14's chew up on 12/14/19 at 2:00 p.m. after he gave it to her; she did not know why Resident #14 didn't ask for the chew back on 12/14/19 at 6:00 p.m. smoke break. Staff J reported as of 12/15/19 morning, Resident #14 still didn't have his chew back. Staff J stated Resident #14 did ask her on 12/15/19 for his chew sometime between 9:00 a.m. and 1:00 p.m. and confirmed her progress notes lacked documentation of a time when Resident #14 asked for the chew. Staff J confirmed she did not contact security at the time of Resident #14's request for his chew as she did not feel it was a priority.</p>			
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	<p>5. The MDS assessment dated 7/11/19 for Resident #8 identified an original admit date of 1/5/18. The MDS coded the resident with clear speech and ability to make self-understood as well as understood others with clear comprehension. The MDS recorded a BIMS score of 09 without signs/symptoms of delirium. A score of 09 indicated moderate cognitive impairment. The MDS revealed the resident required extensive physical assistance of 2 persons for transfers but independent with no set up help for locomotion off the unit. The MDS documented diagnoses that included non-Alzheimer's dementia, depression, chronic lung disease, impulsiveness, nicotine dependence, and alcohol induced persisting dementia.</p> <p>The care Directives dated 1/13/20 informed staff the resident independent with manual wheelchair for locomotion on/off the unit. Under Negative Behaviors the Directives documented Target behaviors of: inappropriate smoking; combative with cares at times; agitation; and suicidal comments due to depression/no longer able to smoke. The interventions included: report any negative behaviors to licensed staff and any suicidal comments to RN and supervisor ASAP; leave safely and return later if yelling or combative with cares; attempt to decrease stimuli - soft music, lights low, etc.; make sure basic needs are being met such as thirst, hunger, toileting, pain, rest, etc.; and attempt to distract resident from smoking such as visiting, 1:1 time, take to canteen for snack, take outside if weather is appropriate, offer activities such as games/cards, movies, music, etc.</p>			
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	<p>The care plan problem area dated 1/4/19 and updated 10/14/19, identified the resident confused at times due to forgetfulness and wandered around. The resident with some jerking movements that caused skin tears and needed reminders about activities offered to him to fill the void for the time as he was now not smoking.</p> <p>The Goal Evaluations dated 4/17/19 documented the resident remained safe and appropriate for open unit at that time as no wandering or trespassing that quarter, benefited from frequent reminders, and he primarily only left the unit to smoke or occasionally eat in ADR (Assisted Dining Room). The resident able to seek out staff for assistance when needed. The resident had 3 inappropriate smoking incidents that quarter and on a smoking restriction of 1 cigarette at a time, which worked well. A goal about safe smoking to be added to the care plan. Under the activities goal, the evaluation documented the resident continued to need to be prompted as to where to go for activities, where the smoke room was off the unit, and provided a chance to be escorted. The resident very much interested in smoking for his free time and spent time in the smoke room or outside on nice days.</p> <p>The Goal Evaluation dated 7/16/19 under activities goal documented the resident desired just to smoke and due to not being allowed to smoke on recreation trips, along with his level of dementia in comprehension of that, it was not a very therapeutic outing for the resident; especially trips to the casino as that was his focus of the trip along with gambling. As the resident got more comfortable with the smoking procedures, they would try the casino in the future. The resident continued to smoke and needed direction to get smokes then reminded where the smoke room located.</p>			
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	<p>The Goal Evaluation dated 7/18/19 documented the resident continued to remain safe and free from harm with no documentation of inappropriate smoking that quarter. Smoking privileges for the resident increased but noted he was being taken advantage of by another resident so his privileges were placed back to 1 cigarette an hour to decrease him from being taken advantage of; no issues with that. Resident rarely left the unit unless to go smoke and able to seek out staff when he wanted or needed something. The Goal Evaluation dated 10/12/19 under activities documented the resident now a non-smoker due to having many infractions of the rules.</p> <p>The Goal Evaluation dated 10/14/19 documented the resident continued to be able to leave the unit independently and return without difficulties as patterned himself; he would occasionally ask which way to go but easily directed and wore a name tag at all times. The resident lost his smoking privileges that quarter due to an unsafe smoking incident when he dropped a cigarette in his lap; he did NOT injure himself at that time. The resident frequently requested to smoke again and stated he didn't understand or remember why he could not smoke any longer. The resident had a couple incidents in smoke room kicking and yelling out; no injuries occurred.</p> <p>The smoking policy form #475-2082, dated as revised 10/17, titled Safety Expectations for Resident Smoking, signed by Resident #8 on 3/8/19 included the following:</p> <ul style="list-style-type: none"> <li>a. Smoking is not permitted in resident rooms.</li> <li>b. Smoking is not permitted by residents in any facility building, entrance, hallway, restroom, public area, or where oxygen is used or stored, except for the smoking rooms located as follows: Dack main floor, Malloy main floor,</li> </ul>			
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	<p>Heinz Hall first floor north lounge. All other units have been designated as completely non-smoking. c. Residents will be re-evaluated following any safety violation or referral regarding smoking incidents by the unit team and can be reevaluated on an "as needed" basis.</p> <p>The Smoking Assessment signed 4/17/19 documented the following: Question (Q) 1 - resident smoked Q2 - resident alert Q3 - resident physically capable of holding a cigarette, matches/lighter, and lighting and extinguishing own cigarette without assistance. Q4 - resident able to extinguish a lit cigarette ash/cigarette which had fallen on his/her person and/or on others Q5 - resident able to call for help if lit cigarette ash/cigarette fell on his/her person or on others Q6 - resident able to move without assistance to designated smoking area Q7 - resident had a past history of poor judgment regarding safety of himself or others Q8 - checkbox left blank to indicate the resident did not have medical contraindications to smoking Q9 - resident instructed in facility policy regarding safety of himself or others Q10 - resident signed the Resident Smoking Agreement and Smoker Release of Responsibility Form Q13 - Smoking Status based on Q1 thru Q10 = Unsupervised. Comments - Resident had 3 inappropriate smoking incidents that quarter; 2 of them occurred when smoke room closed and he was found smoking outside of the smoke room and the other incident found smoking in his room. The resident</p>			
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	<p>on a cigarette restriction of 1 cigarette at a time, staff to remove lighter when he returned to the unit, and not to give cigarettes when smoke room closed. The resident had no further smoking incidents since the restriction placed.</p> <p>On 6/19/19 at 8:40 p.m. the Progress Note documented the resident received instruction on the updated designated smoking areas and that oxygen equipment must be stored in appropriate area. The resident verbalized understanding that smoking outside of designated smoking areas would result in immediate removal of smoking privileges until reassessed by their Care Team. Handout letter provided.</p> <p>The Smoking Assessment signed 6/20/19 documented identical information for questions Q1 thru Q13 as 4/17/19 assessment and the resident status remained Unsupervised smoker. The Comments section recorded the resident noted to be smoking safely and appropriately with restriction. The resident increased to 2 cigarettes at a time but noted after a few days another resident had been asking the resident for a cigarette and so the resident not using 2 cigarettes; so the resident changed back to 1 cigarette at a time so he would not be taken advantage of.</p> <p>The Smoking Assessment signed 7/18/19 documented identical information for questions Q1 thru Q13 as 6/20/19 assessment and the resident status remained Unsupervised smoker. The Comments section recorded identical information as well.</p> <p>On 7/18/19 at 8:55 a.m. the Progress Note documented a Quarterly Mood Assessment. The assessment included documentation the resident had a bit of difficulty adjusting</p>			
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Facility Administrator

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Date

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	<p>to some of the new smoking rules recently implemented. The resident took himself off the unit, really enjoyed smoking, and still asked how to get to and from the smoke room; not a new behavior and he generally did well and appeared patterned. The resident voiced no needs at that time, denied any feeling of depression, enjoyed spending time in the smoke room, and did not ask for anything other than to be able to smoke. Under Restrictions, the assessment documented for staff to keep the residents cigarettes for him in the treatment room and provide him 1 at a time when asked.</p> <p>On 7/18/19 at 10:26 a.m. the Progress Note documented a Nursing Head-to-Toe Assessment.</p> <p>Under Orientation the assessment included the following about the resident: alert and oriented to self; knew to seek out staff for things he needed or wanted; BIMS score of 9 stable; did not have decision making abilities and a guardian in place; able to go to the smoke room or outside or to the ADR to eat and back to the unit without need for assistance to find his way, rarely chose not to leave the unit otherwise; and occasionally asked which way to go when wanting to leave the unit to smoke and after being directed toward elevator, able to find his way there and back. Under Psychosocial the assessment included the resident: at times refused cares or showers but rarely frustrated or combative with ADL's (Activities of Daily Living) as he was upon admission; kept to himself; smoked and wore a smoking apron; no smoking issues that quarter and attempted to increase restriction to 2 cigarettes at a time but due to another resident taking advantage of him went back to receiving only 1 cigarette at a time to avoid that; denied</p>			
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	<p>depression or anxiety; and received medications for depression with history of suicide attempt, insomnia.</p> <p>The incident report categorized as type Equipment/Environmental Smoking dated 7/29/19 at 3:30 p.m. documented the smoke room attendant reported Resident #8 dropped a cigarette and ashes on his lap. The resident left the smoke room with the lit cigarette on the floor. The supervisor made aware of the incident and the resident not to have any cigarettes until the IRCC team met to place a plan of care.</p> <p>On 7/30/19 at 8:35 a.m. the Progress Note documented an RN Directive Update the resident not to smoke for 1 week starting 7/29/19 with rationale for the change as unsafe smoking.</p> <p>At 8:54 a.m. the Progress Notes documented an order received to start the resident on the nicotine patch 14 gm (grams) per 24 hours for 6 days due to the resident's smoking restriction of no cigarettes for 1 week started the day before.</p> <p>Review of the clinical record lacked documentation the resident or the resident representative/guardian notified and/or gave consent for nicotine patch.</p> <p>On 7/31/19 at 10:27 a.m. the Progress Note documented the resident continued to ask for cigarettes and cursed at staff when explained he couldn't smoke for a week. At 9:23 p.m. the notes recorded the nicotine patch came off the resident during his shower and order received to reapply the patch in the morning.</p> <p>On 8/1/19 at 9:58 a.m., Staff S, RN, wrote a Progress Note to record Resident #8 in the smoke room and would not leave as he was on a smoking restriction. Resident #8 sat in the smoke room holding onto an UNLIT cigarette which he</p>			
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	<p>handed to a peer when Staff S entered the room. Staff S asked the peer to leave the room and Resident #8 asked who made those rules. Staff S explained to Resident #8 he was on a restriction due to unsafe smoking and Resident #8 responded that was bullshit. Staff S instructed Resident #8 he needed to smoke safely to be able to smoke at all, needed to follow the rules/restrictions to get smoking privileges back, and he had a nicotine patch on to which the resident replied it was not enough. Staff S recorded staff aware the resident would continue to need frequent reminders of smoking restriction.</p> <p>On 8/2/19 at 10:06 a.m. Staff E, RN, wrote a Progress Note to record she received a call from the smoke room monitor stating Resident #8 in the smoking room. Staff E and Staff R, LPN, went to the smoke room to find Resident #8 done smoking and he did not have smoke guard on. Staff E wrote the resident came out of the smoke room without argument and reminded he was not to be smoking. When the resident asked why, staff talked to him about how he dropped a lit cigarette and borrowed cigarettes. Staff E asked how he got the cigarette and lighter but he did not remember who gave him the cigarette; the lighter given to the resident by the smoke room monitor who replaced the regular monitor for a break and did not know the resident on a restriction. The monitor educated to read the book available with specific instructions and restrictions. Staff E added to the resident's care plan no smoking until further notice but as resident already on a 1 week no smoking restriction and a nicotine patch, restriction extended until nursing supervisors available for discussion.</p> <p>On 8/3/19 at 3:29 a.m. the Progress Note recorded Resident #8 asked many times that shift about smoking and did not remember from 10 minutes before that he had been</p>			
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	<p>informed he could not smoke to which he replied that is bullshit.</p> <p>On 8/5/19 at 2:01 p.m. the Progress Note documented a call placed to the doctor regarding the resident not able to smoke at that time, the nicotine patch being discontinued, and a new order received for the nicotine patch 14 mg/24 hours to be applied daily.</p> <p>Review of the clinical record lacked documentation the resident or the resident representative/guardian notified and/or gave consent for continuation of the nicotine patch.</p> <p>On 8/9/19 at 9:54 p.m. the Progress Note documented at 5:50 p.m. security called to report Resident #8 sat in front of the smoke room waiting for the doors to be unlocked. The supervisor redirected the resident back to his unit, easily redirected, and the resident stated he did not remember he could not smoke.</p> <p>On 8/11/19 at 9:49 a.m., Staff S wrote a Progress Note to record Resident #8 asked her for a cigarette and he was reminded he could no longer smoke. When the resident asked why, Staff S informed him he smoked unsafely several times and the decision made he could not smoke any longer. The resident replied, f*** them, he would just commit suicide then. Staff S asked the resident to repeat himself as his words sometimes mumbled and the resident stated, he'd just kill himself then. Staff S asked the resident if he had a plan to do that and he replied, he would hang himself with the sheet, tie it, wrap it around his neck, and hang himself. Resident #8 sat in his doorway of his room in a wheelchair and when he stated that he pointed to his bed to the sheet. Staff S encouraged the resident not to do that and they would discuss with the supervisor; the resident nodded head in agreement. The supervisor called and the resident placed on 1:1 until further notice with the psychiatrist</p>			
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	<p>notified. The AM supervisor visited with Resident #8 and he denied making suicidal comments. At 10:52 a.m. the notes documented the resident indicated no immediate plan to harm himself and did not recall making any such comment shrugging with a slight laugh when mentioned. The resident explained he would be a lot better if he could smoke and reminded of the nicotine patch to assist his body with the transition of not smoking. The resident unable to recall specifically the events that led up to his smoking being taken away. Staff to ensure the patch offered/in place with 1:1 kept in place due to level of frustration expressed and prior comments made until the team could evaluate on 8/12/19.</p> <p>On 8/12/19 at 1:19 p.m. the Progress Note documented a psychiatry note. The psychiatrist documented the resident with poor recall of recent events with increasing forgetfulness, in particular, asking repeatedly for cigarettes while forgetting he was not allowed to smoke due to recent smoking restrictions placed on him. The assessment recorded the resident seemed stable, assured to many staff members he was not serious when he made the statement of self-harm/suicide, was a chronic smoker, and for him it was very difficult decision to accept and come to terms with. The resident's memory questionable and staff would discontinue the 1:1 observation and continue frequent checks. Under Plan, the physician wrote orders to continue mirtazapine (antidepressant medication, sertraline (antidepressant medication) and divalproex (anticonvulsant medication) for treatment of behaviors related to neurocognitive disorder. A GDR (Gradual Dose Reduction) contraindicated between now and the next planned assessment as it would likely worsen symptoms especially related to his adjustment to current smoking restrictions.</p>			
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	<p>On 8/14/19 at 10:45 a.m. the Progress Note documented unit clinic rounds completed with discussion on whether to renew or reduce the resident's nicotine patch with decision to continue the nicotine patch at 14 mg per day. Review of the clinical record lacked documentation the resident or the resident representative/guardian notified and/or gave consent for continuation of the nicotine patch. On 8/15/19 at 9:42 p.m., the Progress Note documented the resident asked for a cigarette and when told he could no longer smoke, the resident replied he would smoke if he wanted to and bum a cigarette; but the resident returned to his room and did not go downstairs.</p> <p>On 8/16/19 at 11:43 a.m., Staff E wrote a Progress Note to record Staff F, RN/NS (Nursing Supervisor), received a call Resident #8 went into the smoke room in Malloy with his O2 stroller on. The resident did NOT have a cigarette or lighter on him. The monitor noticed O2 (oxygen) and told the resident he needed to avoid going in and the resident not to be in the smoke room at all. Resident #8 ignored the request to leave the smoke room and the monitor physically pulled the resident out of the smoking room while he kicked and screamed. Upon return to the unit, staff noticed the O2 not turned on nor was the NC (nasal cannula tubing) in the resident's nares as the O2 PRN (as needed). The resident's SPO2 (blood oxygen level) 96% RA (room air) [indicated the resident not actively using the oxygen at the time of the incident]. The O2 stroller removed from the resident's wheelchair and 1:1 time spent talking to resident about putting himself and others at risk. The resident responded, who cares and continued to ask when he could smoke again. Staff E reminded the resident he had several incidences of unsafe smoking and had broken his restriction several times</p>			
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	<p>to which the resident responded that was bullshit and he wanted to speak to the Commandant.</p> <p>The incident report categorized as type Miscellaneous Other dated 8/16/19 at 11:44 a.m., created by Staff E, documented the same information as the Progress Note and again recorded when Resident #8 entered the smoke room the oxygen NOT turned on. The monitor told the resident he could not go in, Resident #8 refused to stop, and the monitor physically pulled the resident out of the smoke room kicking and screaming. Resident #8 did NOT have a cigarette or a lighter. The nursing supervisor comment section recorded the resident not allowed to smoke at all but had not been happy with that and continued to try to enter the smoke room. The smoke room attendants aware the resident not to be in the smoke room but the resident could be belligerent at times about that. Staff able to remove his oxygen as his O2 sats (saturation) remained greater than 90%. The intervention to be the resident no longer had oxygen stroller on wheelchair and staff to continue to educate/remind the resident he could not smoke or be in the smoke room.</p> <p>On 8/16/19 at 8:54 p.m. the Progress Note documented the resident took himself down to the smoke room and attempted to get a cigarette from the staff sitting there. The attendant reminded him he could not smoke and he had a nicotine patch; the resident brought back to the unit and reminded he needed to talk to his PN (Primary Nurse).</p> <p>On 8/17/19 at 9:26 a.m. the Progress Note documented the resident continued to ask about smoking and several attempts made to redirect.</p> <p>On 8/22/19 at 3:14 p.m. the Progress Note documented the resident continued to be very upset over the inability to smoke any longer and frequently asked several staff for cigarettes and why he wasn't able to smoke. The resident</p>			
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	<p>stated he was in the service for 10 years, fought for freedom, but in a prison with no rights. Staff S reminded the resident several unsafe smoking incidents occurred and he did not remember that. The resident replied he would just bum a smoke off someone and when told he couldn't do that and he wore O2 again, the resident responded he would get rid of it then and wheeled back to his room. At 10:10 p.m. the notes recorded the resident continued to ask for cigarettes and upset when told he could not smoke.</p> <p>On 8/27/19 at 9:13 a.m. the Progress Note documented the resident asked when he could get his cigarettes back and reminded him his privileges taken away due to unsafe. The resident replied, oh bullshit he was there and alive so it couldn't be too bad. After Staff S explained he now wore oxygen most of the time and if he smoked accidentally with it on he could harm himself and others by starting a fire, the resident responded he didn't care if anyone got blown up because if he couldn't smoke then no one could and he might as well die. Resident #8 denied any suicidal comments or harm to others but was just making a statement of how he felt and continued to state the nicotine patch didn't help with his cravings. The resident declined encouraged activities to help distract him from wanting cigarettes. A message left for the psychiatrist regarding reviewing the resident's medications for possible increased depression symptoms.</p> <p>On 8/28/19 at 11:30 a.m. the Progress Note documented unit clinic rounds completed with question for Chantix (medication for smoking cessation aid) as nicotine patch ineffective and per the psychiatrist, the facility protocol Chantix to be ordered by medical provider and mental health to follow up with patient monthly.</p>			
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	<p>On 8/30/19 (Friday) at 9:58 p.m. the Progress Note documented the resident educated on the no smoking bac and a slightly firmer approach than normal used with the resident told he had been in trouble multiple times and he would never be able to smoke a real cigarette at the facility. The resident asked for an E-cigarette and educated the nurses wanted to attempt it but he had said no way; the resident responded well he changed his mind, give him an E-cigarette. The note recorded a few emails would be sent to the resident's nurses and they could get back to him on Tuesday (9/3/19).</p> <p>On 9/18/19 at 3:00 p.m. the Progress Note documented the resident asked to smoke and reminded he was not able to do that any longer to which he asked, why couldn't he?</p> <p>On 10/10/19 at 9:25 a.m., the Progress Note documented the resident approached the Malloy smoke room and attempted to enter with his O2 on. The resident did not make it through the doorway when he was immediately stopped and moved away from the smoke room. When the resident asked why he couldn't smoke, staff informed him he just demonstrated an unsafe practice by attempting to enter the smoke room with oxygen on. Resident #8 loitered by the Malloy smoke room for a few minutes before propelling himself back towards the Malloy elevators.</p> <p>On 10/13/19 at 3:46 p.m. the Progress Note documented a Nursing Head-to-Toe assessment. Under Psychosocial, the notes recorded the resident usually quiet, cooperative, and at times refused cares or showers but rarely frustrated or combative with ADL's as he was upon admission. The resident kept to himself but had become a little more social with staff and peers in the last quarter. The resident no longer able to smoke due to unsafe incident when he dropped a cigarette on his lap, did not get injured, but</p>			
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	<p>deemed no longer able to smoke per facility smoking rules. The resident used a nicotine patch, would continue to ask about it and requested to smoke at times becoming upset when denied. The resident made a suicidal comment times 1 due to not being able to smoke although he denied it a short while later. The resident had a few incidents where he went into the smoke room and refused to leave with attempt to borrow cigarettes from peers. The resident's requests to smoke decreased in the last few months and he denied any depression or anxiety when asked, just stated he felt down at times about having to live at the facility and not at home. On 10/17/19 at 8:17 a.m. the Progress Notes documented a Quarterly Mood Assessment. The assessment recorded the resident had 1 unsafe smoking episode and lost his smoking privileges that quarter and it had been a challenge for him to adjust to because he didn't retain the information. The resident had gone back several times and tried to enter the smoke room and been prevented from doing so with a great deal of redirection from staff regarding his smoking losses. On 10/22/19 at 3:01 p.m. the Progress Note documented a Quarter Meeting Report. The report documented the resident's concerns were about wanting to be able to smoke again but due to unsafe smoking incidents, he lost his privileges permanently. On 10/28/19 at 11:46 a.m. the Progress Note documented order received to decrease the nicotine patch to 7 mg/24 hours as the resident had not been asking for cigarettes often. On 11/18/19 at 3:45 p.m., the Progress Note documented the nicotine patch discontinued as the resident no longer needed it and did not ask for cigarettes any longer. Observation on 1/2/20 at 1:06 p.m. revealed the interior smoking room in the Malloy building located on the 1st</p>			
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	<p>floor unlocked. Several residents present in the room actively smoking with 3 staff members present to assist and monitor the area; Staff A, RN, Staff B, RN, and Staff C, RTW. Staff C stood at a cart with drawers and a book on the top.</p> <p>The book contained the following information: Resident #8, lived on M2S (Malloy 2nd floor South) - Not allowed; call #620 (supervisor) if attempts.</p> <p>At the time of observation, Staff C commented Resident #8 begged and even cried over not being allowed to smoke. Staff C stated staff often respond to Resident #8's request to smoke with, it's been so long since he quit he didn't need to smoke.</p> <p>On 1/16/20 at 2:40 p.m., Staff N, Compliance Officer, reported the Commandant could neither confirm nor deny if the Commandant ever spoke with Resident #8 per Resident #8's request made on 8/16/19 as he did not document when he spoke with residents. Staff N reported the facility could not pinpoint who the monitor for the smoke room was on 8/16/19 in reference to the Progress Notes entry the resident pulled from the smoke room kicking and screaming.</p> <p>6. The MDS assessment dated 11/6/19 for Resident #9 identified an original admit date of 6/4/09. The MDS recorded a BIMS score of 08 without signs/symptoms of delirium. A score of 08 indicated moderate cognitive impairment. The MDS coded no behaviors exhibited during the 7 day look-back period. The MDS revealed the resident required the extensive physical assistance of 2 persons for transfer and independent without set up help for locomotion</p>			
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<b>Rule or Code Section</b>	<b>Nature of Violation</b>	<b>Class</b>	<b>Fine Amount</b>	<b>Correction date</b>

	<p>on/off the unit. The MDS documented diagnoses that included cerebrovascular accident (CVA), non-Alzheimer's dementia, central nervous system disorder, and nicotine dependence.</p> <p>The care Directives identified the resident independent with manual wheelchair with locomotion on/off the unit and his boundaries to be facility grounds. Under General Condition the directives informed staff the resident smoked with family off grounds, an E-cigarette available for use on grounds, and monitor for smoking materials on person and room. Under Negative Behaviors a history of inappropriate smoking documented and staff directed to encourage the resident to go off the unit with staff maybe to canteen but make sure they told the resident it was not to smoke.</p> <p>The care plan problem area created 6/27/19 and updated 11/13/19 identified the resident wanted to continue smoking when out with family. The Goal Evaluation dated 11/13/19 documented the resident had 2 unsafe smoking incidents the past quarter on 8/18/19 and 8/22/19. The resident no longer smoked on facility grounds and only when out of the facility with family. The resident with no signs of injury or unsafe smoking upon return to the facility when he had been out with family.</p> <p>The Smoking Assessment signed 2/5/19 documented the following:          Question (Q) 1 - resident smoked          Q2 thru Q11 left blank.          Q12 - Smoking Status based on Q1 thru Q10 = Supervised smoker.          Comments - The resident only smoked when family came and took him as he lived on a secured unit and could not be left unattended. The resident supervised due to history of unsafe smoking and there were no issues as family returned</p>			
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Facility Administrator

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Date

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	<p>smoking materials when they brought the resident back to the unit.</p> <p>On 5/9/19 at 2:47 p.m. the Progress Note documented Resident #9's family member stated she would be speaking with the Commandant about the resident moving off the secured unit as it was very depressing for the resident and she would like to see him go back to an open unit. No further smoking issues occurred nor did the resident get stuck outside as family took him and didn't leave him unattended.</p> <p>On 5/10/19 at 3:04 p.m. the Progress Note documented a smoking restriction placed at the canteen previously and the resident continued to smoke in the designated areas with family members. Smoking remained a very important past time for the resident as it was an opportunity to visit with friends he made over several years.</p> <p>On 6/20/19 at 12:41 p.m. the Progress Note documented Resident #9's family member notified of the new smoking policy. Staff discussed with the resident and family member the 2 designated areas for smoking; Malloy smoke room and outside east of MLRC, both familiar with the areas. The family member took the resident at that time to smoke and followed the guidelines set up on the care plan; no issues and the resident able to light, hold his own cigarette and wore a smoke guard.</p> <p>On 6/22/19 at 5:37 p.m. the Progress Note documented Resident #9's family member spoke that afternoon with the Commandant and informed him she received permission from the Administrator allowing her to be in the smoke room with Resident #9. After follow up, the Commandant found out that was not true and the Commandant left the family member a voicemail a little after 3:00 p.m. letting her</p>			
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	<p>know she did NOT have permission to be inside the smoke room with the resident and staff also notified.</p> <p>On 6/25/19 at 8:32 a.m. the Progress Note documented due to the change in facility smoking policy, the resident now a candidate for transfer back to an open unit and a request for room transfer provided to the primary nurse.</p> <p>On 7/16/19 at 12:07 p.m. the Progress Note documented the family member notified the previous evening of the resident move that day to Malloy 3rd floor North and the resident excited to be going back.</p> <p>At 2:32 p.m. the Progress Note documented the resident asked to smoke and able to verbalize back he needed a smoke guard. Escort provided to the smoke room with the resident needing some direction on how to get there.</p> <p>Resident #9 given 1 cigarette and lighter and the resident able to light own cigarette, smoked safely, did not extinguish cigarette but did place in ash tray, and when prompted to distinguish placed in the bottom of the ash tray. The resident asked for another cigarette and again lit cigarette, smoked safely, did not extinguish cigarette but placed in bottom of ash tray, and educated again about extinguishing it. The resident gave the lighter back to staff.</p> <p>At 8:47 p.m. the Progress Note documented the resident's family member assisted the resident down to smoke at 8:00 p.m. The family member reported she was not allowed in the smoke room as she was yelled and cursed at by specific staff and would not enter the smoke room again until she was apologized to. The resident entered the smoke room on his own and placed himself by an ash tray after prompted. The resident able to properly light 4 cigarettes in 10 to 15 minutes, hand with involuntary movements, and able to hold onto cigarettes the entire time he smoked. The resident: did not properly ash every time with a few ashes landing on side</p>			
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	<p>of ash tray; ashed once on the floor; and wore a smoke guard not long in length that covered his legs, but did not ash on his legs, slippers or toes. The resident placed all cigarettes in ash tray but did not put out prior to placing in the ash tray so education provided regarding proper smoking that was not performed.</p> <p>On 7/17/19 at 10:39 p.m. the Progress Note documented the resident self-propelled to the Malloy smoke room which was closed from 5:30 p.m. to 6:00 p.m. and the resident commented he would go outside and smoke then. Staff reminded the resident there was no smoking allowed outside and prompted the resident to self-propel to the Dack smoke room. The resident able to light and hold all cigarettes on his own without concerns, ashed appropriately with very scant amount of ash on the front of smoke guard, and missed ash tray when he smoked 1st cigarette. The cigarette hit the floor and the resident did not attempt to pick it up. The resident got another cigarette out and attempted to light it and staff entered the smoke room to educate regarding the cigarette on the ground which the resident could not reach on his own. Education provided to request assistance and options available with smoking monitor. Staff sent 4 smoke guards to mending to have another guard added to them to make them long in length to cover the resident's legs and feet; 3 long smoke guards in the resident's room at the time. The unsigned Smoking Assessment with a reference date of 7/17/19 documented the following:          Question (Q) 1 - resident smoked          Q2 - resident alert          Q3 - resident physically capable of holding a cigarette, matches/lighter, and lighting and extinguishing own cigarette without assistance.</p>			
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	<p>Q4 - resident able to extinguish a lit cigarette ash/cigarette which had fallen on his/her person and/or on others          Q5 - resident able to call for help if lit cigarette ash/cigarette fell on his/her person or on others          Q6 - resident able to move without assistance to designated smoking area          Q7 - resident had a past history of poor judgment regarding safety of himself or others          Q8 - resident had medical contraindications to smoking          Q9 - resident instructed in facility policy regarding safety of himself or others          Q10 - resident signed the Resident Smoking Agreement and Smoker Release of Responsibility Form          Q12 - Smoking Status based on Q1 thru Q10 = Supervised smoker.          Comments - Resident moved to M3N (Malloy 3rd floor North). The resident unable to pick up cigarette if dropped on the floor on his own, did not request assistance by smoking monitor or other residents present in the smoke room to pick up the cigarette off the floor, and did not always ash appropriately. The resident and family member aware the resident was to continue to have family supervise smoking at that time. The resident had 3 smoking assessment since transfer yesterday.          On 7/18/19 at 2:47 p.m. the Progress Note documented the resident able to propel himself without difficulty to and from the Malloy smoke room. The resident's family member assisted the resident to apply a long smoking apron, the resident able to hold and light cigarette appropriately on his own, and resident ashed in ash tray appropriately. The resident smoked 3 cigarettes while in the smoke room and each time he smoked half of a cigarette and then put into ash</p>			
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	<p>tray without extinguishing first. The resident returned the pack of cigarettes and lighter upon exiting the smoke room. The unsigned Smoking Assessment with a reference date of 7/18/19 documented the same information as 7/17/19 assessment for Q1, Q2, Q3, Q5, Q6, Q9, and Q10.</p> <p>Q4 - checkbox left blank to indicate the resident not able to extinguish a lit cigarette ash/cigarette which had fallen on his/her person and/or on others</p> <p>Q7 - checkbox left blank to indicate the resident did not have a past history of poor judgment regarding safety of himself or others</p> <p>Q8 - checkbox left blank to indicate the resident did not have medical contraindications to smoking</p> <p>Q12 - Smoking Status based on Q1 thru Q10 = Supervised smoker.</p> <p>Comments - The resident able to propel himself without difficulty to and from Malloy smoke room. The family member assisted the resident to apply long smoking apron and the resident able to hold and light cigarette appropriately on his own. The resident placed ashes in ash tray appropriately and smoked 3 cigarettes while in the smoke room. Each time the resident smoked half of a cigarette and then put it into ash tray, however, did not extinguish cigarette prior to putting into ash tray. On 7/18/19 at 9:05 p.m. the Progress Note documented the resident self-propelled to the smoke room after supper and knew his way there. The resident prompted at the smoke room door to cover his feet with a smoking guard, to ash and extinguish cigarettes appropriately. The resident did not cover his feet until prompted. The resident able to open a new pack of cigarettes, smoked 3 cigarettes, lit, ashed, and extinguished all safely. The resident pressed the lever on</p>			
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	<p>the ash tray to dump the cigarette butts when done smoking and returned cigarettes, lighter to staff.</p> <p>The unsigned Smoking Assessment with a reference date of 7/19/19 documented the same information as 7/17/19 assessment for Q1 thru Q10 except Q4 left blank.</p> <p>Q4 - checkbox left blank to indicate the resident not able to extinguish a lit cigarette ash/cigarette which had fallen on his/her person and/or on others</p> <p>Q13 - Smoking Status based on Q1 thru Q10 = Unsupervised smoker.</p> <p>Comments - Late entry for 7/18/19. The resident smoked safely during assessment, extinguished cigarettes and ashed appropriately, as well as covered his toes with the smoking guard after prompted twice; see NN (Nurses Notes) for further details.</p> <p>On 7/19/19 at 2:06 p.m. the Progress Note documented an RN Directive Update recording the new directive the resident a smoker. Staff instructed to give the resident 3 cigarettes, the resident to obtain lighter from the smoke room attendant, the resident to return the lighter when he exited the smoke room, long smoke guard to be worn to cover body, and family to supply cigarettes. The rationale for change documented as the resident assessed and safe to smoke, would have resident sign smoking agreement before smoking on his own.</p> <p>On 7/26/19 at 8:55 p.m. the Progress Note documented the resident brought back a blue lighter to the unit from the smoke room which should have been left with the smoke room monitor.</p> <p>The incident report categorized as type Resident Behavior Other dated 7/28/19 at 4:30 p.m. documented when getting the resident up out of bed, staff found a blue lighter with the resident's name on it that had fallen out of his shirt pocket</p>			
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	<p>onto the bed. Staff re-educated the resident that he was to leave it with the smoking attendant to which he replied he forgot, he thought he had left it there. The pouch attached to the resident's armchair continued to fall off and that was where the resident had placed his lighter and cigarettes before. A note placed on the report to see about fixing the pouch and possibly a sign posted by the handicap button in smoke room stating to hand in lighter.</p> <p>On 8/14/19 at 6:27 a.m. a Smoking Assessment completed and noted the resident: a smoker; knew the designated areas; got to smoking areas independently; lit smoking material safely, independently; did not shake/tremor while smoking; could extinguish smoking materials completely in an appropriate receptacle; did not fall asleep while smoking; had a past accidents/incidents with smoking materials on 5/20/18 when a cigarette butt found on top of his right foot with a burn mark to the top of slipper/foot and history of burn holes in clothing and wheelchair pad; restrictions in place of 3 cigarettes at a time and resident to obtain lighter from the smoke room monitor and return it when done; smoking care plan and interventions in place of a long smoke guard that covered his legs and feet; no incident occurred; and safety expectations reviewed and signed.</p> <p>At 8:26 a.m. the Progress Note documented smoking remained a very important past time for the resident as it was an opportunity to visit with friends he made over several years.</p> <p>The Safety Expectations for Nursing Resident Smoking policy revised 08/19 (1st version) recorded Resident #9 unable to sign on 8/15/19 and included the following documentation:</p>			
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	<p>a. Residents will be re-evaluated following any safety violation or referral regarding smoking incidents by the unit team and will be reevaluated on an "as needed" basis.</p> <p>b. Any unsafe smoking incidents or violation of safety rules will result in removal of smoking materials until the incident can be evaluated by the unit team or designee. Every unsafe smoking incident or safety violations will result in action steps that may lead to restrictions in the ability to keep cigarettes and lighters/matches with a resident, up to and/or including permanent removal of smoking privileges.</p> <p>The incident report categorized as type Equipment/Environmental Smoking dated 8/18/19 at 1:00 p.m. documented the smoke room monitor reported the resident put a piece of toilet paper used to wipe his face on top of the ash tray then another resident opened the ash tray causing the paper to fall in and it began to smolder; the attendant extinguished using a cup of water. The resident educated not to put paper waste into the ash tray and reminded to use the garbage can outside of the smoke room. The supervisor comment section noted the resident using a battery operated smoking device.</p> <p>On 8/18/19 at 2:44 p.m. the Progress Note documented the resident used a piece of toilet paper to wipe his face then put it on top of the ash tray. Another resident opened the ash tray causing paper to fall into the ash tray. Paper began to smolder and smoke room attendant extinguished using a cup of water.</p> <p>On 8/21/19 at 11:57 p.m. the Progress Note documented the resident's family member took the resident off grounds to smoke as the resident remained unable to smoke at that time due to an incident of dropping cigarette on the floor.</p>			
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	<p>Review of the clinical record lacked documentation of an incident report related to the resident dropping a cigarette. On 8/22/19 at 3:12 p.m. the Progress Note documented the resident's family member informed Resident #9 could no longer smoke due to incident of dropping cigarette and past history of unsafe smoking. The family member upset and stated she would appeal the decision and wanted to see film of the incident; the facility denied having access to security footage.</p> <p>At 4:22 p.m. family member requested the resident be allowed to return to previous smoking arrangement of being able to smoke when family or friends there with the resident 1:1. The facility discussed with the family member the use of an E-cigarette instead. The note recorded the family member satisfied with the compromise as it promoted the resident's independence, desire to smoke, and socialization that he enjoyed in the smoke room.</p> <p>On 8/23/19 at 3:00 p.m. the Progress Note documented a RN Directive Update for Smoking. The note recorded the resident: could use a disposable E-Cigarette only, no regular cigarettes; needed to request from staff; family to supply E-cigarettes; and rationale for the change due to recent smoking incidents.</p> <p>At 3:53 p.m. the note recorded education given to the resident regarding the care plan change for use of E-cigarette only, not to bum or smoke cigarettes or other smoking material, and reminded not to bring paper products into the smoke room.</p> <p>The Safety Expectations for Nursing Resident Smoking policy revised 08/19 (2nd version) recorded Resident #9 unable to sign on 9/3/19 and included the following documentation:</p>			
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	<p>a. Any single incident of unsafe smoking, including any incident of unsupervised smoking or any activity that put other residents at risk, would result in immediate, permanent removal of smoking privileges.</p> <p>On 11/5/19 at 10:54 a.m. the Progress Note documented a late entry for 11/1/19 regarding a letter the facility becoming smoke free on 1/1/20. The letter reviewed and discussed the resources available to assist with smoking cessation. Resident #9 signed acknowledgement stating he was aware violations of the smoke free policy may result in administrative discharge. Resident #9 noted to comment he did not smoke at the facility anymore as he was only allowed to smoke E-cigarettes and went out with family to smoke. Staff explained they still wanted to give him the notification.</p> <p>On 11/7/19 at 1:25 p.m. the Progress Note documented a RN Directive Update recording smoking interventions for the E-cigarette discontinued as the resident not smoking at that time.</p> <p>On 11/13/19 at 8:34 a.m. the Progress Note documented the resident had a smoking incident that quarter when he dropped a lit cigarette and lost his privilege to smoke. The resident tried an E-cigarette but did not like it so he smoked cigarettes with family off campus when they were able to take him off grounds. Staff reminded the family not to leave smoking materials in his room. The resident to wear a smoking guard while smoking and smoking remained a very important past time for him as an opportunity to visit with friends he made over several years.</p>			
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	<p>Observation on 1/2/20 at 1:06 p.m. revealed the interior smoking room in the Malloy building located on the 1st floor unlocked. Several residents present in the room actively smoking with 3 staff members present to assist and monitor the area; Staff A, RN, Staff B, RN, and Staff C, RTW. Staff C stood at a cart with drawers and a book on the top.</p> <p>The book contained the following information: Resident #9, lived on M3N (Malloy 3rd floor North) - E-cigarettes brought by family and may carry them himself. Staff C commented Resident #9 went to Ulery for a while due to smoking issue. When asked to clarify if the facility considered e-cigarettes the same as cigarettes, Staff C and Staff A both responded yes. Staff A then stated Resident #9's sheet must be inaccurate to say he may carry the e-cigarettes as the correct answer should be he is not allowed.</p> <p>On 1/6/20 at 1:45 p.m. an interview conducted with Resident #9 and his family member. The family member reported Staff M, SW, and the Safety Director, who had never seen Resident #9 before, told them the resident could no longer smoke that summer. The family member commented the cardiologists said it took 7 years from stopping smoking for effects to benefit a person and they said the resident might as well keep smoking as he had a limited life expectancy. The family member stated the resident had a very complicated central nervous system vasculitis (inflammation of the blood vessels that causes changes in the blood vessel walls) which was rare but started in his brain. The family member reported the facility previously compromised the resident could smoke as long as family or a friend with him; he couldn't put the smoke guard on himself. The family member reported Resident #9</p>			
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	<p>previously moved in the year 2018 from Malloy building, first to Fox building and then a few weeks later to the Ulery building. The family member reported as of 6/22/19 Resident #9 continued to reside in Ulery. The family member stated they made 4 trips a day for Resident #9 to be able to smoke. The family member recalled an incident where she sat in the smoke room and heard the Commandant's voice; she clarified the incident happened during the month of June 2019 when a survey being conducted at the facility. The family member reported the Commandant said she and Resident #9 could not be in the smoke room. The family member stated she went out of the room and tried to explain the situation of the compromise made when she appealed the resident's move from Fox building to Malloy. The family member stated a meeting had been held which included the Ombudsman and the Administrator; Commandant was not present. The family member commented the Commandant did not want her in the smoke room. The family member stated she would put the smoke guard on the resident, give him a cigarette, then watch from outside the room; but the Commandant said she was not to be in that smoke room. The family member expressed concern on how the Commandant communicated to her over the situation. The family member stated before the end of the day she had a voice mail with the Commandant stating she was incorrect. The family member reported the facility moved Resident #9 back to Malloy the past summer (2019) she thought to pacify her as she did not know the rationale; the facility just moved the resident while she was at a funeral. The family member stated within a couple weeks the facility started letting the resident go down to smoke by himself. The family member voiced surprise she didn't have to be there with the resident but it only lasted</p>			
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Facility Administrator

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Date

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Citation**

<b>Citation Number:</b> 8001		<b>Date:</b> February 6, 2020		
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	<p>2 weeks when all of a sudden the facility made the resident a non-smoker. The family member reported the facility said the resident dropped a lit cigarette on the floor which they deemed an incident. The family member requested to see the security tapes but denied access. The family member stated a different resident informed her they had picked up the cigarette for Resident #9 and it had not been lit. The family member reported she knew of another resident who lost smoking privileges from dropping ashes when reaching to flick a cigarette then made a non-smoker. The family member commented the facility kept a book with a list of residents who were no longer allowed to smoke. The family member reported the Commandant placed police tape around an area where smoking to be outside and voiced he didn't like smoking saying in the 1st 2 weeks when he came that the facility would be smoke free within 2 years. The family member said each day the cones kept getting closer and closer so no room to go to the outside area and the guys enjoyed being out in nature with a cigarette. The family member reported she now took Resident #9 off the property every day for him to be able to smoke. The family member commented as soon as she arrives on the property the facility follows her and makes her feel they will kick Resident #9 out of the facility. The family member reported the facility took away smoking from Resident #9 in August or September 2019.</p> <p>On 1/6/20 at 3:44 p.m. the Administrator responded she had developed a list of smoking incidents for surveyors for why residents' privileges revoked and wanted to explain her notes. The Administrator said the resident's family member a real advocate for other residents and very involved in the facility. The Administrator reported Resident #9 previously lived in Malloy where he smoked unsafely, which was</p>			
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	<p>before the VA survey (June 2019). The Administrator reported Resident #9 moved from Malloy where all his smoking friends resided to Fox building to maybe be safe. The Administrator stated the resident moved to the Fox building instead of Ulery building, which was a locked unit, so he would have the most ability to not be on a locked unit yet not be so close to the smoking area. The Administrator stated the resident kept bumming cigarettes, dropping ashes, got burns on his feet, and couldn't handle smoking safely. The Administrator stated Resident #9 got people to push him over to the hill to smoke on the other side of road as he couldn't get there on his own; since still a risk they met with the family and moved Resident #9 to the Ulery building for safety. The Administrator commented it was a real loss for the resident and his family took him outside every day to smoke, back when residents could smoke outside. The Administrator stated then the whole change occurred when the facility went to supervised smoking, so they gave Resident #9 an opportunity to go to back to the Malloy building, but he had more incidents of unsafe smoking so now the family member took him in a van off grounds to smoke.</p> <p>7. The Quarterly MDS with an assessment reference dated 11/7/19, documented Resident #4 with diagnosis for which included Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA) or stroke, Non-Alzheimer's Dementia, Depression and Psychotic disorder. The MDS documented the resident with a BIMS score of 14 for which indicated no impaired decision making abilities, and now mood indicators for which included trouble falling or staying asleep, or sleeping to much, poor appetite or overeating and now a score of 3, over the last 2 week period.</p>			
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	<p>The MDS also documented the resident as independent with locomotion on and off the unit with the use of a wheelchair as the mobility device.</p> <p>The Quarterly Minimum Data Set (MDS) with an assessment reference dated 8/13/19, documented Resident #4 with diagnosis for which included Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA) or stroke, Non-Alzheimer's Dementia, Depression, Psychotic Disorder and Schizophrenia. The MDS documented the resident with a Brief Interview for Mental Status (BIMS) score of 11 for which indicated moderately impaired for decision making capabilities, with no mood indicators and total severity of mood left blank, locomotion on the unit as independent and off the unit as total dependence of one person for physical assist with the wheelchair as the mobile device.</p> <p>The Careplan Directives printed on 1/13/20, documented the resident as independent on mobility with the wheelchair on the unit and off the unit to be escorted with staff, name tag with green dot, sign out on CAR 54 when leaving the unit and boundaries.</p> <p>The careplan problem area updated on 5/10/19, stated resident need for assistance with activities of daily living and continued inappropriate response to internal frustration/feeling of powerlessness. Resident was moved to an open unit early this quarter as it was felt he no longer needed a secured environment for safety. He was given smoking privileges upon moving but had an incident when he lit up a cigarette outside of the smoke room and lost his cigarette privileges and then asking peers and staff for matches and demanding to smoke again, it is believed that</p>			
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	<p>he may have been getting cigarettes from peers and smoking outside although this is after the observation period. He has had some inappropriate behaviors when he has yelled and cussed at staff.</p> <p>The careplan problem area updated on 9/13/19, stated I will remain safe when smoking, with an up date of 11/14/19, with goal not met, resident had lit up a cigarette outside of the smoke room this quarter and lost his smoking privileges. He declined using a nicotine patch or gum. He has been noted to have gotten cigarettes somehow recently as was seen smoking outside although this was after the observation period. He is now moved to a secured unit in Ulery.</p> <p>A Smoking Assessment completed on 5/16/19, documented the resident as a non-smoker.</p> <p>On 5/20/19 at 12:55 p.m., the progress note documented Resident is frustrated about being placed on a secured unit and will often refuse activities on the unit. Resident is very focused on going to canteen and wants to get cigarettes. Resident said would be satisfied when gets to go where can smoke again.</p> <p>On 5/29/19 at 1:47 p.m., the progress note documented resident able to make needs known, a wheelchair used as primary mode of locomotion and is able to propel self on unit. Resident resides on a secured unit and requires escort using Car 54 for all off-unit activities/appointments.</p> <p>On 9/13/19 at 10:33 a.m., the progress note documented resident transferred to unit Malloy 2 south from unit Ulery 1 around 9:15 a.m., reviewed smoking changes, funds</p>			
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	<p>restrictions, etc. Resident aware that writer will assess smoking abilities this afternoon. Resident also upset when found out not able to leave Iowa Veterans Home grounds but did eventually state was agreeable to this.</p> <p>A Smoking Assessment completed on 9/13/19 at 3:07 p.m., documented new assessment due to move to open unit from secured unit-had previously smoked prior to moving to secured unit. The resident is a smoker, able to know the locations of the designated areas to smoke, is able to get to the areas independently, can safely light smoking materials safely, can extinguish smoking materials completely in an appropriate receptacle, and a smoking careplan is in place.</p> <p>A Nursing Facility Visit dated 9/24/19 at 2:30 p.m., documented resident at Malloy building for initial IMPACT visit and a regulatory visit. Resident is confused at times and oriented times 2. Recently has moved from another building and continues to smoke, uses a wheelchair for mobility. Staff and resident have no concerns and has tobacco dependence.</p> <p>A Facility Incident Report dated 10/14/19 at 1:55 p.m., documented an adverse event occurred without harm to resident. While writer was monitoring the smoke room it was noted that when resident handed smoking materials prior to entering the smoke room, the resident lit the cigarette while sitting in wheelchair next to the smoking supplies cart. Resident treatment worker (RTW) states, "what are you doing?" Resident then immediately went into the smoking room and finished smoking the cigarette. This incident was then reported to the primary nurse. Cigarettes removed form smoke room, switchboard, and no smoking</p>			
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	<p>note placed on cigarette Medication Administration Record (MAR) in smoke room. Resident made aware of no longer being able to smoke due to incident and facility rules and became very angry at writer and wheeled away in wheelchair. Resident no longer able to smoke. Resident is not smoking and all smoking material has been removed from resident and smoking room cart. Resident not happy about not being able to smoke but is not currently using a patch, gum or lozenges to assist with with drawl from smoking. Resident has been accepting of this even though not happy about it.</p> <p>On 10/14/19 at 2:26 p.m., the progress noted documented, received report that resident had lit up a cigarette outside of smoke room just after staff had give a cigarette and then when staff spoke to him, he realized what he had done and rushed in to smoke room to smoke the cigarette. Resident not on unit at this time and will let resident know his smoking privileges have been revoked when he returns.</p> <p>An Elopement Risk dated 11/7/19, documented the resident with a score of 6 for which a low risk for elopement and if 8 or above represents risk for elopement. Resident has made verbal comments about leaving but has not made any attempts to leave the grounds</p> <p>A Progress note dated 11/8/19 at 7:06 a.m., Quarterly note, resident attends Dack gym, Monday-Friday at 6:30 a.m., and several times throughout each day for resident directed exercise program consisting of using the Sci-Fit, 10 times for 20 minutes. Resident attendance has been good this quarter, resident will remain on Dack gym caseload and attend as able.</p>			
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	<p>An entry in the progress notes dated 11/8/19 at 8:54 a.m., resident in Malloy 2 south, resident in a wheelchair and is able to propel own chair, if you don't agree resident gets mad, although this has been better since his move back over here.</p> <p>On 11/11/19 at 1:35 p.m., a progress noted documented at 8:15 a.m., staff report overhearing resident mentioning that he would get a cigarette from someone and that it is stupid that "we" are keeping him from smoking. Writer noted to be at smoke room during open hours and did not see resident make any attempt to ask peers or go into smoke room. Resident notes to stay off unit all day except once mid morning.</p> <p>On 11/12/19 at 5:37 a.m., the progress note documented at 5:15 a.m., writer called to the unit by staff. 10:00 p.m.- 6:00 a.m., staff report resident was up at 2:30 a.m., and off the unit until 5:00 a.m. At 5:00 a.m., resident came back to the unit requesting to use the toilet. 2 staff from the 10:00 p.m., - 6:00 a.m., staff assisted resident and the noted a strong smell of smoke on his clothing. Writer along with 2 staff from the 10:00 p.m. - 6:00 a.m., RTW went to his room and when questioned resident about smoking he instantly became angry and ordered me out of his room. He refused to allow me to check the pockets of his jacket stating, "Get the hell out of here.". I reminded resident he no longer has smoking privileges. Writer checked the bag on the wheelchair and noted no smoking materials. Writer contacted security requesting the cameras be checked. At 8:12 a.m., the progress noted documented resident emphatically denies smoking, or being around anyone who</p>			
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	<p>was smoking this morning. Resident is very angry, wants to leave and is demanding money. Writer has provided resident with the new smoking policy. Writer provides resident with 3 canteen books a week if not more. We have shared the on going concerns about smoking and the potential consequences with him.</p> <p>At 8:52 a.m., the progress noted documented room check completed by writer and did not find any smoking materials.</p> <p>On 11/13/19 at 5:09 a.m., a progress noted documented resident off unit most of shift.</p> <p>A Social Work Quarterly dated 11/13/19 at 9:57 a.m., documented resident was recently moved to an open nursing unit form memory care at Iowa Veterans Home in September 2019. He was afforded the opportunity to be back in open nursing and had expressed a desire to return and to begin smoking again. He agreed to the rule that we presented to him by his Ulery team and also our Malloy team. Since his move back he was evaluated for smoking and able to smoke per our guidelines at the time. However in October, he lost those privileges. Since that time his behaviors have continue and his anger and irritation as he uses the unit phone to call and attempt to call attorneys, ombudsman and his sister. Resident given his deficits and inability or willingness to comply, it appears that this opportunity is not successful as recently resident was found to have gone outside in shorts and a shirt in very cold temperatures. This has prompted safety to rise to the forefront requiring that resident be transferred back to a more secure setting.</p> <p>At 4:28 p.m., on 11/13/19 a progress note documented phone call to sister, explained concerns about possibly</p>			
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	<p>smoking and wether and him being caught outside in cold weather without proper dressed and he will be moving back to Ulery specifically household #6 tomorrow. Writer encouraged her to say that the facility has observed him putting himself in a unsafe situation and we need to ensure his safety.</p> <p>On 11/14/19 at 3:03 a.m., a progress note documented switch board called unit to inform staff that resident was outside in courtyard yelling by the door by switchboard to get back inside. Switchboard staff let resident back in and when asked why he was outside, resident stated "I needed fresh air." A strong cologne odor noted on resident. Resident also noted to only have shorts and a long sleeve shirt on.</p> <p>At 4:27 a.m., on 11/14/19, it was documented at this time writer observed resident sitting in his wheelchair in the Malloy main south hallway facing toward the Malloy smoke room. I reminded him that all doors are locked and need to stay in doors related to cold temperatures.</p> <p>At 5:51 a.m., on 11/14/19 it was documented writer observed resident in his manual wheelchair sitting in line for breakfast in the ADR. Resident has made no further attempts to exit the building.</p> <p>At 9:31 a.m., on 11/14/19 it was documented writer received notice from security officer that witnessed resident smoking in the courtyard the a.m., at approximately 8:15 a.m., resident was wearing shorts. resident had left the area by the time the security officer was able to exit the building.</p> <p>At 9:15 a.m., it was documented resident arrived on the unit escorted by staff. Has made comments about not wanting to be here and that he doesn't plan to stay long. Requested the phone to call the police. Declined to eat lunch and his noon</p>			
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	<p>dose of medicine. He also declined to allow skin treatment to his shin.</p> <p>At 11:44 a.m., on 11/14/19 it was documented resident and belongings moved to U6. care conference given.</p> <p>At 2:35 p.m., with RN directive update: Directive Section: locomotion off unit New Directive: Escort must stay with resident when off the unit, name tag with green dot, sign out on CAR 54 when leaving unit, and boundaries.</p> <p>Rationale for change: Resident is now resides on KU6, a secure unit due to being noncompliant with smoking and also going outside in cold weather with short and a t-shirt.</p> <p>At 2:43 p.m. on 11/14/19 it was documented, received call stating that resident was seen smoking outside in the courtyard in his shorts this a.m., around 8:00 a.m.- 8:30 a.m., resident alerted to return to the unit and writer informed him that how was seen doing this, he paused for a few seconds and then yelled "I don't care if they seen me, I should be allowed to smoke!" Resident declined to answer who or where he had gotten a cigarette from. He was again reminded that he lost his smoking privileges and needed to follow IVH rules regarding this and that due to cold weather it was not safe for him to be outside an was not dressed appropriately to go outside either and then was told that he would be moving balk to Ulery due to unsafe as it being the 3rd time in a few days he was outside with inappropriate clothing and smoking inappropriately. Resident angry and stating he would not go and that he wanted to call the police to turn "us" in as we were taking away his rights.</p> <p>At 3:15 p.m., it was documented writer spent 1-1 time with resident times 2 today. Apologized for what is happening to him and provided reassurance that we can work together and hope at some point he can return to an open unit since he</p>			
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	<p>was happier there. Writer will confer with social worker and work with his careplan team in implementing a plan for an escort to the canteen on a regular basis with the restorative aide.</p> <p>At 4:18 p.m., on 11/14/19 it was documented resident remains very impatient and will frequently demand to get up at 3:00 a.m.- 4:00 a.m., in morning even after agreement to wait until 6:00 a.m. He also is no longer able to smoke due to lighting a cigarette outside of smoke room and frequently requesting to be able to smoke again or becomes angry and states it is his right to smoke.</p> <p>At 4:30 p.m. on 11/14/19, it was documented as a quarterly comment that residents BIMS increased from 11 to 14.</p> <p>A Resident Transfer Worksheet with no date, time or signature, documented, resident was observed (security surveillance) 11/12/19, to go outside around 5:00 a.m., the Malloy southeast doors to the courtyard. Resident was dressed in short and t-shirt and the temperature was less than 10 degrees. Resident was off unit from 2:30 a.m.-5:15 a.m., and staff reported while assisting with toileting that he smelled strongly of smoke. Resident denied smoking and when security footage was reviewed they report that he appeared to put something in his mouth but turned his back to the cameras. Yesterday an unlit match was found on the bathroom floor. From 11/1/19-11/7/19 there were 3 documented incidents of him asking staff for matches. Resident boundaries are the Iowa Veterans Home grounds.</p> <p>A Orders Search Report dated 11/14/19 at 3:31 p.m., documented resident transfer to Ulery secured unit due to safety.</p>			
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	<p>A Ulery Memory Care Unit Policy Number 212A with no date, stated the purpose/philosophy is to provide a safe and secure living environment for residents with neurocognitive disorders or residents exhibiting behaviors that are unsafe to themselves or others. Procedure:</p> <p>* Criteria for admission to the memory care units: *A physicians order is required for admission or transfer to the memory care units. Resident Care Conference (RCC) teams will utilize form 475-1687 for referrals. Residents will be admitted/transferred to the appropriate household to best meet their needs as identified in the teams assessment.</p> <p>*Ulery 1, 2, 3, and 6 - Secure Units: Behaviors range from active exit-seeking to aggressive and trespassing behaviors. Residents are typically in middle to late stages of the cognitive loss or need specialized care to address a behavior that may cause harm to self of others.</p> <p>During an interview on 1/15/20 at 11:04 a.m., with the facility administrator, confirmed that the residents was moved from malloy to ulrey due to safety concerns for him being outside on 11/12/19 and that there is no dementia referral on him it was a decision that was made by the team for the safety of the resident to put in ulrey secured unit. She stated that she will see if the facility kept the footage of the surveillance cameras for the time frame of the resident being outside, she commented that they did review the tape and that she is not sure of how long he was outside and that she will try to find the tape.</p> <p>During an interview on 1/15/20 at 12:30 p.m. the facility administrator confirmed and verified that there is no video camera footage on the day of 11/12/19, according to her the</p>			
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	<p>nurse stated that the resident came back to the open unit at 5:15 a.m., to go to the bathroom and that he smelt like smoke so the nurse asked security to review the footage on the camera to see if he was out smoking, they reviewed the camera in the courtyard and noticed that he was outside at 5:00 a.m., but could not distinguish if he was smoking or not and that he was in shorts and a short sleeve shirt. And that again he was placed in ulrey secured unit for his safety of being outside with out the proper clothing on. The facility administrator also went on to say that on another incident the resident was outside again, could not remember the exact date when it happened, but the resident was in the court yard and was heard by the staff at the front desk of loftus, and the resident was yelling to come inside and that the staff went to the door and let the resident in.</p> <p>During an interview on 1/15/20 at 1:50 p.m., the resident remembered going outside on that particular day and just needed some fresh air, and that he still wants to go outside and still wants to be able to smoke. He stated that he never had an education or directives to wear long pants or long sleeves when he goes outside, he stated that he is aware of the need to wear long pants and a coat and is still very angry that he is placed in the secured unit and that he is not happy there and wants to get to another part of the facility where he can come and go as he pleases.</p> <p>8. The Quarterly MDS with an assessment dated 10/22/19, documented Resident #12 with diagnosis for which included hypertension, anxiety, bipolar disorder and nicotine dependence. The MDS documented the resident with a BIMS of 15 for which indicated the resident with no cognitive impairments and able to made decisions,</p>			
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	<p>independent in all aspects of daily living, and a walker is used for a mobility device, and no limitations with range of motion or balance during transitions and walking.</p> <p>The residents directive with a print date of 1/13/20, resident as independent with walker on unit and off unit, boundaries-Iowa Veterans Home grounds, may go off grounds with family or rec staff only. Needs to sign out on CAR 54 if going out with family.</p> <p>The residents plan of care dated 10/25/19, I desire independence in selecting what I do in my leisure time: Please provide me personal reminders about activities I enjoy such as the unit special meals, outings, and unit social events. Goal evaluations on 4/29/19, goal met and remains consistent with residents desire regarding the use of leisure time. Over the past has gone to the casino on a couple of occasions. He also enjoys walks and spends time during the day over at Heinz Hall with friends he made during his stay there.</p> <p>7/29/19, Goal Met: Over the past quarter resident was going on trips to the casino to be able to purchase his tobacco. Now with the new smoking rules resident told that he wouldn't be going on any recreation trips. Reassured him that she does not make the rules, but just has to carry out those laid out by the upper administration. He stated that he could take the shuttle and go on his own and then be able to smoke while at the casino. Resident continues to have a certain group of friends that he smokes and associates with. Resident continues to have a certain time which he rolls his cigarettes and also time which he lays down during the day.</p>			
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	<p>10/28/19, Goal Met. Resident states that he is satisfied with the use of his leisure time. He continues to visit with peers when smoking and when he is out and about the facility.</p> <p>The plan of care address a problem on 6/26/19, Smoking, I enjoy smoking and want to continue to smoke while I am living at Iowa Veterans Home. Approaches include:          *Nursing will educate me on safety expectations for smoking every 90 days and as needed.          *Nursing will inform me of any changes in smoking rules right away so I can continue to smoke.          *Staff aware that I desire to take the casino shuttle every other Monday to buy supplies to roll my own cigarettes and my schedule will be posted in chart room.</p> <p>Goal Evaluations:          7/25/19-Goal Met: Resident has not and any negative behaviors with smoking. He continues to follow all of IVH and VA smoking regulations. He does wear a smoke guard when he smokes per his choice. Resident did sign safety expectations after writer reviewed with him. He is able to retain the education that is given to him.          10/21/19- Goal Met: Resident has not had any negative behaviors with smoking. He does desire to continue to roll his own cigarettes. Resident has been requesting to frequent the casino more often. He has signed a smoking assessment and understand the expectations. He does understand that he in not to smoke at casino, is aware if it is witnessed he may lose his smoking privileges.</p> <p>The Smoking Assessment completed on 7/23/19, stated that the resident does smoke, is alert, is physically capable of holding a cigarette, matches/lighter, and lighting and extinguishing own cigarette without assistance, is able to</p>			
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	<p>move without assistance to designated smoking areas, and has signed the Resident Smoking Agreement, and is Unsupervised to smoke.</p> <p>The Safety Expectations for Nursing Resident Smoking policy revised 06/19 and signed by the resident on 7/23/19, recorded any incidents or safety violations of safety rules will be reported and evaluated by the unit team and/or Safety Officer. Incidents or safety violations are subject to action steps that my lead to restrictions in the ability to keep cigarettes and lights/matches with you up to and/or including discharge to a different facility.</p> <p>The Safety Expectations For Nursing Resident Smoking policy revised 8/19, and signed by the resident on 8/15/19, recorded any unsafe smoking incidents or violations of safety rules will result in removal of smoking materials until the incident can be evaluated by the unit team or designee. Every unsafe smoking incident or safety violations will result in action steps that my lead to restrictions in the agility to keep cigarettes and lighters/matches with a resident, up to and/or including permanent removal of smoking privileges. At any time the nursing staff or Safety Officer may remove the smoking materials (cigarettes and lighter/matches) due to health and safety concerns until a permanent decision can be made.</p> <p>The Safety Expectations For Nursing Resident Smoking policy revised 8/19, and signed by the resident on 9/3/19, recorded any unsafe smoking incident or violations of safety rules will result in immediate, permanent loss of smoking privileges. Please let us know if you are interested in smoking cessation assistance.</p>			
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	<p>On 9/4/19 at 10:36 a.m., an late entry from 9/3/19, documented in the progress notes, spoke with resident to discuss changes to the safety expectations for nursing resident smoking guideline. Education and letter provided. Resident very upset over new rules, however, resident did sign smoking expectation form.</p> <p>An initial IMPACT visit dated 9/23/19, documented resident alert and oriented times 3, affect appropriate, no focal neurological deficits.</p> <p>On 10/2/19 at 8:49 a.m., an RN directive in the progress notes documented locomotion off unit, may go to salvation army, grocery store and casino on his own. He is to tell staff and sign out on CAR 54. Desires to purchase items at casino and grocery store. Ok by Malloy 2 North team.</p> <p>On 10/9/19 at 8:19 a.m., documentation in the progress notes that careplan reviewed and up dated. Boundaries appropriate.</p> <p>IVH Smoking Assessment completed on 10/21/19 at 10:38 a.m., documented in the progress notes that resident is a smoker, knows the locations of the designated areas to smoke, can get to the areas independently, and wear a smoke guard.</p> <p>An Elopement Risk Assessment completed on 10/21/19, documented the resident with a score of 4, for which indicated low risk for elopement.</p>			
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	<p>A Nursing head-toe assessment completed on 10/21/19, documented resident with normal communication, BIMS 15/15, no change, has a daily routine, arises early, requests his medications then leaves the unit to smoke. He is on and off the unit all day.</p> <p>On 11/1/19 at 2:19 p.m., documentation in the progress notes that writer met with resident in his room to provide him with a letter of notification regarding the Iowa Veterans Home becoming a smoke-free on January 1st, 2020. The letter was reviewed with resident and we discussed the resources that are available to assist with smoking cessation. Resident signed the acknowledgement form stating he received this letter and that he is aware violations of the smoke free policy may result in administrative discharge.</p> <p>On 11/5/19 at 9:46 a.m., documented in the progress notes, when writer was on day off, 11/4/19, at the casino, writer saw resident smoking.</p> <p>At 12:51 p.m., documentation in the progress notes that resident was witnessed to be smoking by recreation staff yesterday at the casino and was reported to administration today. M2N team discussed with resident today, and resident denied smoking. Resident then stated that we had told him it was okay per social worker documenting on 9/26/19 and verification by staff witnesses to the conversation resident was informed he could not smoke at the casino. Resident upset because as of today he has lost his smoking privileges per IVH administration. Resident initially declined to have smoking replacement, then requested the patch about 10 minutes later. Cigarettes will be removed from the Dack smoke room cart.</p>			
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	<p>At 4:23 p.m., documentation from 11:45 a.m., documented writer notes that resident was observed smoking at the Meskwaki casino yesterday by an IVH recreation staff person who then reported this to IVH administration this morning. As resident is nursing level of care and was smoking off grounds unsupervised his smoking privileges are being removed today per IVH policy. Resident informed of this decision by his primary RN, NS and writer prior to lunch. Resident initially denied that he was smoking and stated that writer had informed him that he could smoke at the casino. He was then reminded of our conversation that we had on 9/26/19 about his going to the casino which included instruction from writer that as nursing level of care resident that he could not smoke unsupervised. He then became upset stating "You are all trying to take away my smoking early" He then stated he didn't want to talk to us and needed to take his medications. A short time later he came to this writer to ask who turned him in. He also then told writer that he only smoked 2-3 cigarettes and that he was careful and didn't think anyone saw him. Resident encourage by writer to think about utilizing a nicotine patch or some sort of nicotine replacement therapy instead of going cold turkey. Resident agreed and nursing staff was informed of this. Resident remains upset about his smoking privileges being removed. Will remain available to resident to provide support as needed.</p> <p>At 5:14 p.m., documentation in the progress notes that resident was observed by unit to exchange money with a Heinz Hall resident and receive a pack of cigarettes. Resident approached writer in the basement of Dack and informed him that I was aware he had just purchased a pack of cigarettes and reminded him that he was not allowed to have his own cigarettes. I asked to take them to the</p>			
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	<p>Switchboard. Resident willingly gave writer the pack of cigarettes. Taken to Switchboard.</p> <p>An Incident Equipment/Environmental smoking dated 11/5/19 at 5:17 p.m., documented resident was observed to exchange money with a Heinz Hall resident and receive a pack of cigarettes. Resident approached writer in the basement of Dack and informed him that I was aware he had just purchased a pack of cigarettes and reminded him that he was not allowed to have his own cigarettes. I asked to take them to the switchboard. Resident willingly gave writer the pack of cigarettes. Take to switchboard. Resident again educated on rules to be able to remain at IVH. Set up for staff to check his room and his person every shift for smoking materials. He voices understanding.</p> <p>On 11/5/19 at 9:25 p.m., it was documented in the progress notes that resident was started on Nicotine patches tonight. Resident had no behaviors over smoking resident only said "this is a bunch of bullshit."</p> <p>On 11/6/19 at 5:04 a.m., progress notes documented resident up and about the unit early today approximately 1:30 a.m. Reports he was smoking at Meskwaki casino and got turned in so his smoking privileges were taken away. Resident does not mention he was caught buying cigarettes last night. Resident reports he is going to try to find somewhere else to live. Resident sits in a chair in front lobby area mumbling on and on staff unable to hear what he is saying and unaware of who he is speaking to.</p> <p>At 8:57 a.m., on 11/6/19, writer spoke with resident this a.m. about his purchasing a pack of cigarettes from a Heinz Hall resident last evening. The nurse supervisor in Heinz</p>			
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	<p>Hall was able to speak with resident about this and the cigarettes were removed from his person. Writer reiterated that with the loss of his smoking privileges yesterday that he is not allowed to smoke at IVH anymore and can not possess any smoking materials as well. WE also discussed that since he is now on a nicotine patch that it is not recommended that he smoke with this on. Writer further discussed that is he is observed buying/possessing/smoking cigarettes that this could lead to additional interventions such as a total funds restriction and possible discharge form IVH due to continued violations. Resident verbalized understanding with the above discussion. Will plan to continue to provide follow up counseling/reminders as needed.</p> <p>At 9:56 a.m., late entry for 9:00 a.m., documented writer met with resident to discuss the incident of him buying cigarettes from a Heinz Hall resident last evening. He immediately states "He got them back" Writer explained that when his smoking privileges were revoked that meant that he was not to be smoking at all in any capacity. He was told that he is not to have any smoking materials on him or in his room. Shared the expectations with him again and he voiced understanding. He was also made aware that staff would be checking his person and his room every shift for an smoking materials and that if any are found it could lead to other intervention to discharge from IVH. He then stated "I wish they would discharge me. I would go live in an apartment close to my parents."</p> <p>On 11/7/19 at 10:19 p.m., documentation in the progress notes stated that resident had reported to day shift that the nicotine patch was making him dizzy so he took it off.</p>			
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	<p>Resident wanted to keep using the patch but requested a smaller dose.</p> <p>A behavior note dated 11/12/19 at 8:02 a.m., documented mood worse this month. Has been reporting pain in his upper back, neck and scapula. Seeking out more pain medications. Has been more anxious with the new smoking rules. Has been going to casino to purchase his tobacco then smoke there which is against IVH protocol. Has been requesting his noon medications earlier to accommodate taking the casino bus. Resident can be very anxious, obsessive and yell at staff. Will become anxious about his medications times and if he does not get them on time. Also will be paranoid think he is in trouble or people are talking to him.</p> <p>An Equipment/Environmental incident dated 12/20/19 at 11:51 a.m., documented that resident was observed smoking at Hy-Vee unsupervised by nursing staff. Team was asked to follow up with resident upon his return to IVH. It was also noted that resident had not signed out on the CAR 54 book on the unit. At approximately 1:45 p.m., resident was paged back to his unit, resident came back to unit and met with him in his room. Inquired where he had been and resident reported that he went to Hy-Vee to pick up deodorant. Resident was then asked what he did while he was at Hy-Vee. Resident again reported that he went to pick up some deodorant. Resident was then informed that he had been observed smoking. Resident initially asked "who saw me?" Resident told that it didn't matter who saw him but that he was smoking off grounds unsupervised and that per VA all nursing level of care residents needed to be supervised when smoking. Also discussed that he had previously lost his</p>			
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	<p>smoking privileges and was on a nicotine patch. Reviewed that IVH currently has a 3-strike policy and that with the first violation he would be counseled. WE also discussed that further violations could lead up to administrative discharge after the 3rd strike. Resident was informed that he would be receiving a letter from IVH administration notifying him of this violation and receiving a strike. Again reinforced the IVH policy and seriousness of this matter. Resident was then asked if we could search his room and if he had any other cigarettes/smoking materials in his possession. resident did get up and go over to his coat rack and gave writer a pack of camel cigarettes and a lighter. It is noted that there were only 4 cigarettes left in the pack. Room search was completed and no further smoking materials were found. Resident was also reminded to sign out from the unit when he leaves IVH grounds. Resident will be receiving a letter from IVH administration regarding his first strike later today.</p> <p>On 12/20/19 at 3:10 p.m., documentation in the progress notes with writer presented a first offense letter from IVH administration regarding his violation of the IVH smoking policy today at Hy-Vee. Resident was given a copy of the letter and reminded to comply with the IVH smoking policy and that he is not allowed to smoke on or off the grounds unsupervised. Copy of letter placed on chart and in social worker file. Resident verbalized understanding of this letter and his first offense.</p> <p>On December 20th, 2019 a letter with the heading of Iowa Veterans Home with the purpose of this letter is to inform you of your first offense pursuant to Iowa Administrative Code section 801-10.43 (35D) which states:</p>			
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	<p>* The commandant or designee shall administer and enforce all rules adopted by the commission, including rules of discipline and, subject to these rules, may immediately suspend the membership of and discharge any member from IVH for infraction of the rules when the commandant or designee determines that the health, safety or welfare of the members of the IVH is in immediate danger and other reasonable alternatives have been exhausted.</p> <p>The administrative rules allow the Iowa Veterans Home to issue a first offense notification and options relating to noncompliance with the IVH Resident Smoking Policy.</p> <p>On 9/26/19, you had a conversation with your social worker in which you were reminded you could not smoke at the casino as all nursing level of care residents must be supervised when smoking. On 11/5/19 it was reported you were witnessed (the day prior) smoking at the casino. You were informed on that date your smoking privileges were being removed as you were in violation of the IVH Resident Smoking Policy. Today, 12/20/19, you were witnessed smoking at Hy-Vee prior to getting on the city bus. Your actions are in violation of the IVH Resident Smoking Policy.</p> <p>Please be advised that you are expected to follow the IVH Resident Smoking Policy at all times. Having a second offense will place your residency at IVH on probation and could result in immediate discharge.</p> <p>On 12/24/19 at 12:16 p.m., documentation in the progress notes stated spoke with resident about past behaviors with</p>			
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Facility Administrator

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Date

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	<p>smoking. Discussed with resident that team had decided that he should no longer be going off grounds except with recreation or family. Resident voiced that he would like to live in Heinz Hall. Informed resident that he is nursing level of care and that has not changed. Informed resident that he will be able to go on recreational trips more such as going out to eat. Resident voiced that he like that idea. Resident was also informed he can have his 6:00 a.m., medications now at 4:30 a.m., but no sooner than that.</p> <p>At 11:40 a.m., RN Directive Update: Locomotion off unit, resident is not to go off grounds other than with recreation or family. Resident has been smoking off grounds, also has had cigarettes on him when returns.</p> <p>On 1/4/20 at 3:08 p.m., documentation in the progress notes that mood has been more anxious, he has been seen or witnessed with tobacco products this last month. Resident is still on the nicotine patch but has been extended. He has received a letter regarding his last smoking incident. He is spending more time on the unit, is more paranoid, talking to himself and wanting his med's earlier.</p> <p>During in interview on 1/9/20 at 11:40 a.m., the resident confirmed and verified that he had his smoking privileges taken away from him due to the fact that he went to Hy-Vee to get some deodorant and also to get a pack of smokes so as he waited for the city transit bus he could have a smoke and was seen by someone from the facility who turned him in and that when he got back to the grounds, then to his room, a bunch of people came into my room and told me that I am no longer able to leave the facility grounds and have lots my privileges to smoke and that if I have another incident that the facility will discharge me to another facility. I had no</p>			
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	<p>choice but to use the nicotine patch and stop smoking, the urge is still there and will always be there, I have smoked for many years. I miss my friends that I would smoke with and all I do now is sleep.</p> <p>9. Facility/Campus Overview Review of the facility floor map revealed the facility a large campus consisting of multiple buildings. In the center of campus is the administrative building named Sheeler. When facing north, Fox building located to the east of Sheeler building and Dack building to the north. Going west from Sheeler building is the Malloy building. Going south from the Malloy building is the Ulery building. Ulery building contains 8 individual households/units. Ulery units 1, 2, 3, and 6 are secured locked units observed on 1/7/20 at 3:30 p.m. to require a staff badge to either enter or exit the main unit door. Ulery units 4 and 5 considered open units requiring no badge to enter or exit the main unit door. Ulery units 7 and 8 considered semi-secured units with residents wearing wander guard bracelets. When the bracelets get close to the main unit door, the door automatically locks down preventing a resident from leaving that unit.</p> <p>10. Review of the facility smoking policies revealed several changes occurred within the previous year. The changes to each policy marked in bold below:</p> <p>The smoking policy form #475-2082, dated as revised 10/17, titled Safety Expectations for Resident Smoking, included the following:</p>			
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	<p>Cigarette/Cigar or pipe smoking can pose a threat to the safety of the smoker and others, the following safety expectations must be followed at all times when smoking. Failure to follow these expectations may result in loss of smoking privileges.</p> <p>a. Smoking is not permitted in resident rooms.</p> <p>b. Smoking waste (butts and matches) must be disposed of in designated containers. Partially smoked cigarettes must be disposed of.</p> <p>c. Smoking is not permitted by residents in any facility building, entrance, hallway, restroom, public area, or where oxygen is used or stored, except for the smoking rooms located as follows: Dack main floor, Malloy main floor, Heinz Hall first floor north lounge. All other units have been designated as completely non-smoking.</p> <p>d. Smoking is not permitted within 15 feet of any entryway to any building or within 30 feet of any air intake of any building, with the exception of Fox and Ulery, where there is no smoking outside of the buildings. Smoking is not permitted on the dining patio on the south side of the canteen.</p> <p>e. All oxygen equipment must be turned off and removed to a distance of at least 10 feet from any smoking area.</p> <p>f. Every resident who is a smoker will be assessed upon admission, annually and with any incident, using the Smoking Assessment found in the Assessments folder in the electronic health record.</p> <p>g. All assessments, referrals, and expectations will be completed by the licensed nursing staff. The Registered Nurse may prescribe interventions to keep you safe.</p> <p>h. Difficult cases may be referred to the Safety Officer for further recommendations.</p>			
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	<p>i. Residents will be re-evaluated following any safety violation or referral regarding smoking incidents by the unit team and can be reevaluated on an "as needed" basis.</p> <p>j. Electronic cigarettes must abide by the same rules as any other cigarette.</p> <p>Any incidents or safety violations of safety rules will be reported and evaluated by the unit team and/or the Safety Officer. Incidents or safety violations are subject to action steps that may lead to restrictions in the ability to keep cigarettes and lighters/matches with you up to and/or <u>including discharge to a different facility.</u></p> <p>At any time the nursing staff or Safety Officer may remove the smoking materials (cigarettes and lighters/matches) due to health and safety concerns until a permanent decision can be made.</p> <p>The smoking policy form #475-2082, dated as revised 6/19, titled Safety Expectations for Resident Smoking, included the following:</p> <p>Cigarette/Cigar or pipe smoking can pose a threat to the safety of the smoker and others, the following safety expectations must be followed at all times when smoking. Failure to follow these expectations may result in loss of smoking privileges.</p> <p>a. Smoking is not permitted in resident rooms.</p> <p>b. Smoking waste (butts and matches) must be disposed of in designated containers. Partially smoked cigarettes must be disposed of.</p> <p>c. Smoking is not permitted by residents in any facility building, entrance, hallway, restroom, public area, or where oxygen is used or stored, except for the smoking rooms located as follows: Dack main floor, Malloy main floor,</p>			
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	<p>Heinz Hall first floor north lounge. All other units have been designated as completely non-smoking.</p> <p>d. Smoking is not permitted within 15 feet of any entryway to any building or within 30 feet of any air intake of any building, with the exception of Fox and Ulery, where there is no smoking outside of the buildings. Smoking is not permitted on the dining patio on the south side of the canteen.</p> <p>e. All oxygen equipment must be turned off and removed to a distance of at least 10 feet from any smoking area. Change: removed from the previous policy that every resident who was a smoker would be assessed upon admission, annually and with any incident, using the Smoking Assessment found in the Assessments folder in the electronic health record.</p> <p>f. All assessments, referrals, and expectations will be completed by the licensed nursing staff. The Registered Nurse may prescribe interventions to keep you safe.</p> <p>g. Difficult cases may be referred to the Safety Officer for further recommendations.</p> <p>h. Residents will be re-evaluated following any safety violation or referral regarding smoking incidents by the unit team and can be reevaluated on an "as needed" basis.</p> <p>i. Electronic cigarettes must abide by the same rules as any other cigarette.</p> <p>Any unsafe smoking incidents or violation of safety rules will be reported and evaluated by the unit team and/or the Safety Officer. Incidents or safety violations are subject to action steps that may lead to restrictions in the ability to keep cigarettes and lighters/matches with you up to and/or including discharge to a different facility.</p> <p>At any time the nursing staff or Safety Officer may remove the smoking materials (cigarettes and lighters/matches) due</p>			
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Facility Administrator

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	<p>to health and safety concerns until a permanent decision can be made.</p> <p>The letter typed on facility letter head addressed to all residents of the facility on 6/19/19 documented the following: The Veterans Administration had identified a significant risk to facility residents related to unsafe smoking. Therefore, effective immediately the following practice would be implemented. Smoking would only be permitted for residents in the following 2 supervised designated smoking areas</p> <ul style="list-style-type: none"> <li>a. Malloy smoke room</li> <li>b. Seating area around the umbrella fountain in the courtyard east of the MLRC (Malloy Leisure Resource Center),</li> </ul> <p>a designated area identifiable by orange cones; Residents must place oxygen equipment in the designated storage areas prior to smoking. Smoking outside the designated smoking areas would result in immediate removal of smoking privileges until it could be reassessed by residents' care team. Thank you for their immediate attention in the matter. Respectfully, Facility Administration Change: no longer able to smoke in the Dack smoke room and only able to smoke in 1 designated area outside.</p> <p>The Resident Smoking Policy No. 022, approved 7/1/81, revised 8/2/19, and effective 8/2/19, include the following documentation: Purpose – To outline procedures to follow to ensure safety of residents who smoke, as well as the safety of others in the facility.</p>			
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	<p>Policy – Smoking (to include electronic cigarettes) shall be permitted in designated supervised areas only and is prohibited when oxygen is in use.</p> <p>Procedures –</p> <p>Point 6. Residents who smoke will sign “Safety Expectations for Resident Smoking” (form 475-2082, on admission and with any incident identified.</p> <p>Point 7. Unit teams will utilize the Unsafe Smoking Plan for Nursing Level of Care Residents form 475-2149 for follow-up of all unsafe smoking incidents.</p> <p>The form 475-2149, dated New 08/19, titled Unsafe Smoking Plan for Nursing Level of Care Residents included the following documentation:</p> <p>All unsafe smoking incidents will be handled the same way with the following actions:</p> <p>Point 1. All smoking materials will be removed immediately.</p> <p>Point 2. Staff observing unsafe smoking or receiving the report of the incident will document the behavior in an Incident Report.</p> <p>Point 3. The incident will be reviewed by the unit team or designee to determine the severity of the situation, to provide a new safety plan and issue a strike. The incident will be reviewed with the resident and/or his representative if appropriate. The resident will be made aware of where they are in the strike program and will understand the care plan and interventions related to smoking.</p> <p>Point 4. A smoking assessment will be completed prior to smoking materials being returned to the resident. If the resident is unsafe during the assessment (i.e. dropping cigarette, ashing on self/floor, unable to extinguish cigarette, etc), the resident will continue t be unable to smoke and this information will go back to the unit team.</p>			
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	<p>Point 5. If the resident is safe to resume smoking, they must sign a new Smoking Expectations Form and review with the NSD (Nursing Services Director) or AON (Administrator of Nursing) prior to returning the resident's smoking materials. Action Steps: Incidents or safety violations are subject to actions steps that may lead to restrictions limiting the ability to smoke. After one year with no incidents, actions steps will start over.</p> <p>1<sup>st</sup> Offense – issue 1<sup>st</sup> strike and put an intervention for safety into place. Counsel on safe smoking expectations. If there is no intervention to put into place or the resident cannot smoke safely, they will be unable to resume smoking.</p> <p>2<sup>nd</sup> Offense – issue 2<sup>nd</sup> strike and put an intervention for safety into place. Counsel on safe smoking expectations. If there is no intervention to put into place or the resident cannot smoke safely, they will be unable to resume smoking. Inform resident that any further smoking incidents in the next year will result in permanent removal of their smoking privileges.</p> <p>3<sup>rd</sup> Offense – issue final strike and inform resident their smoking privileges will be permanently removed. With each offense complete the Unsafe Smoking Report (attached). Give a copy of the form to the resident and send the original to Administrator of Nursing.</p> <p>In reviewing residents' clinical records and conducting resident/family interviews, unable to determine if residents received a copy of the facility Policy No. 022 or form 475-2149.</p>			
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	<p>The smoking policy form #475-2082, dated as revised 8/19 (1<sup>st</sup> version), titled Safety Expectations for Nursing Resident Smoking, included the following: Cigarette/Cigar or pipe smoking can pose a threat to the safety of the smoker and others, the following safety expectations must be followed at all times when smoking. Failure to follow these expectations may result in loss of smoking privileges.</p> <p>a. Smoking is not permitted in resident rooms. b. Smoking waste (butts and matches) must be disposed of in designated containers. Partially smoked cigarettes must be disposed of. c. Smoking is not permitted by residents in any facility building, entrance, hallway, restroom, public area, or where oxygen is used or stored. Smoking is allowed by residents in smoking rooms located on the Dack main floor and Malloy main floor. All other units have been designated as completely non-smoking. Change: removed from previous policy the residents' ability to smoke in Heinz Hall first floor north lounge and returned ability to smoke in Dack smoke room. d. Smoking is not permitted anywhere outside on facility grounds. Change: previous policy allowed smoking outside in 1 area and now no longer permitted. e. All oxygen equipment must be turned off and removed to a distance of at least 10 feet from any smoking area. Change: added smoking with oxygen on or oxygen on a person, would result in immediate removal of smoking privileges. f. All assessments, referrals, and expectations will be completed by the licensed nursing staff. A licensed Nurse may prescribe interventions to keep you safe.</p>			
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	<p>g. Cases must be referred to the Safety Officer for further recommendations. Change: previous policy stated only difficult cases may be referred to the Safety Officer and now all cases must be referred.</p> <p>h. Residents will be re-evaluated following any safety violation or referral regarding smoking incidents by the unit team and will be reevaluated on an "as needed" basis.</p> <p>i. Electronic cigarettes must abide by the same rules as any other cigarette.</p> <p>Any unsafe smoking incidents or violation of safety rules will result in removal of smoking materials until the incident can be evaluated by the unit team or designee. Every unsafe smoking incident or safety violations will result in action steps that may lead to restrictions in the ability to keep cigarettes and lighters/matches with a resident, up to and/or <u>including permanent removal of smoking privileges</u>.</p> <p>At any time the nursing staff or Safety Officer may remove the smoking materials (cigarettes and lighters/matches) due to health and safety concerns until a permanent decision can be made.</p> <p>Change: Paragraph slightly reworded. Instead of violations being first reported and evaluated before action step of removal of smoking materials, now smoking materials removed due to any unsafe smoking incidents THEN the incident to be evaluated. Instead of incidents MAY lead to restrictions of inability to keep materials and/or actions up to including discharge to a different facility, now every incident WOULD result in action steps that could lead to restrictions of inability to keep materials and/or actions up to including permanent removal of smoking privileges.</p>			
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	<p>The smoking policy form #475-2082, dated as revised 8/19 (2<sup>nd</sup> version), titled Safety Expectations for Nursing Resident Smoking, included the following: Cigarette/Cigar or pipe smoking can pose a threat to the safety of the smoker and others, the following safety expectations must be followed at all times when smoking. Failure to follow these expectations will result in permanent loss of smoking privileges. Change: instead of failures MAY result in loss of smoking privileges, now failures to follow WOULD result in permanent loss of privileges.</p> <p>a. Smoking is only allowed in the smoking rooms located on the Dack main floor and Malloy main floor during the following times: 8:00 a.m. to 9:00 a.m.; 1:00 p.m. to 2:00 p.m.; and 6:00 p.m. to 7:00 p.m. Change: previous policies allowed smoking anytime and now the facility implemented 3 separate 1 hour increments of smoke time a day only.</p> <p>b. Smoking is not permitted in resident rooms. Smoking is not permitted by residents in any facility building or anywhere outside on facility grounds.</p> <p>c. Smoking waste (butts, tobacco, matches, etc.) must be extinguished and disposed of in designated containers. Partially smoked cigarettes must be disposed of and cannot be removed from the smoking room.</p> <p>d. All smoking material (cigarettes, cigars, pipes, tobacco, matches, lighters, etc.) will be stored at the smoking room with the monitors. Change: previous policies allowed residents to maintain possession of their smoking materials and now not allowed to possess any smoking materials.</p>			
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Facility Administrator

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	<p>e. All oxygen equipment must be turned off and placed in the designated oxygen storage area outside of the smoking rooms.</p> <p>f. Any single incident of unsafe smoking, including any incident of unsupervised smoking or any activity that puts other residents at risk, will result in immediate, permanent, removal of smoking privileges. Change: new rule; only needed 1 violation and privileges revoked permanently.</p> <p>g. An unsafe smoking incident may include, but is not limited to: violation of any of the above listed safety expectations; ashes or burn holes on clothing or chairs, burns on skin; falling asleep with a lit cigarette or dropping a lit cigarette on the floor; smoking with O2, taking O2 into the smoking area, or having stroller closer than 10 feet of smoking area - immediate loss of privileges; and any other activity determined to be unsafe and/or put other residents at risk.</p> <p>h. All assessments, referrals and expectations will be completed by the licensed nursing staff. A Licensed Nurse may prescribe interventions to keep you safe.</p> <p>i. Electronic cigarettes must abide by the same rules as any other cigarette. Any unsafe smoking incident or violations of safety rules will result in immediate, permanent loss of smoking privileges. Please let your team know if you are interested in smoking cessation assistance. Change: re-evaluations no longer completed as privileges revoked immediately with encouragement to seek smoking cessation assistance.</p> <p>The letter typed on facility letter head signed by the residents on 11/1/19 documented the following:</p>			
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\_\_\_\_\_  
Facility Administrator

\_\_\_\_\_  
Date

**If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty-five percent (35%) pursuant to Iowa Code section 135C.43A (2013).**

**Iowa Department of Inspections and Appeals  
Health Facilities Division  
Citation**

<b>Citation Number:</b> 8001					<b>Date:</b> February 6, 2020
<b>Facility Name:</b> Iowa Veterans Home		<b>Survey Dates:</b> December 31, 2019-January 22, 2020			
<b>Facility Address/City/State/Zip</b>  1301 Summit Marshalltown, Iowa 50158		MW			
<b>Rule or Code Section</b>	<b>Nature of Violation</b>	<b>Class</b>	<b>Fine Amount</b>	<b>Correction date</b>	

	<p>I have received the letter of notification that the (facility) would be smoke-free as of January 1, 2020. I am aware of the offered supports that are available as outlined in the letter and will work with my RCC team and mental health to find a product or service that will be useful during this difficult transition. I am also aware of any violation may result in Administrative Discharge.</p> <p><b>FACILITY RESPONSE:</b></p>				
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\_\_\_\_\_  
Facility Administrator

\_\_\_\_\_  
Date

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