DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	16A002	A. BUILDING _____ B. WING _____	C 01/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IOWA VETERANS HOME	1301 SUMMIT MARSHALLTOWN, IA 50158

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Investigation of Complaint #87671-C conducted December 31, 2019-January 22, 2020 resulted in the following deficiencies. See Code of Federal Regulations (CFR, Part 483, Subpart B-C)	F 000	F 000 February 6, 2020	
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550	Correction Date February 14, 2020 F550 All staff will be reeducated on resident's rights which will include: 1) The right to have a dignified existence, 2) The right to have self-determination, 3) The right to have communication with and access to persons and services inside and outside of the facility. 4) Treating residents with respect and dignity, and 5) Care for residents in a manner and environment that promotes maintenance or enhancement of his or her quality of life on an individual basis. On December 13, 2019, current IVH residents were notified that they would be allowed to continue to smoke. Residents will continue to be afforded this opportunity under supervision to ensure safety. Residents will have the opportunity to smoke as per times outlined in the IVH facility policy (see attached). The new admission contract was updated as of January 1, 2020, to include that IVH is a tobacco (smoke and smokeless) free campus for all new admissions. All Resident Care Committees (RCCs) will review with each resident who smokes a plan to guide care that ensures individuality while addressing the resident's choice in fulfilling quality of life related to smoking. A standing committee was established 2/12/20, comprised of the Medical Director, Administrator of Nursing, Mental Health Professional and Compliance Officer to review all incidents related to smoking (see attached charter). The immediate goal of this committee is to reevaluate past incidents that have occurred since June 19, 2019, that resulted in the loss of smoking privileges. This will ensure that residents are afforded every opportunity to safely smoke in a supervised setting. Residents moved from their	

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

[signature], LNHA — 2/14/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: 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. 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.	F 550	previous unit solely due to smoking concerns were afforded the opportunity to move back to their previous building. Additionally, residents who smoke that are care planned to leave grounds independently will also be care planned to be able to smoke while off grounds. The ongoing goal of the committee will be to review each smoking incident that occurs daily, in order to provide a fair, consistent and individualized process. Any incident that will result in the permanent loss of smoking privileges will be reviewed with the Long-Term Care Ombudsman. Following each initial and ongoing review, the Resident Care Committee will meet with the resident to develop an individualized plan of care related to smoking. The team will be responsible to assess the smoking plan, quarterly and with any significant change. Residents will be afforded the ability to appeal the decision to a higher level. Notification to the resident regarding this appeal process will be shared with the resident during the Resident Care Committee Review. This committee will report findings to the Quality Committee at each meeting. Completion date: February 14, 2020 Responsible party: LNHA AON	

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F 550	Continued From page 2 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. Findings include: 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. 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. 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	F 550		

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F 550	Continued From page 3 all off unit activities/appointment and were not to leave the resident unattended. 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 plan directed staff to encourage ongoing involvement in the incentive therapy program. 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. 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. 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	F 550		

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F 550	Continued From page 4 next 90 days with next review date in 78 days on 3/31/20. 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 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. 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. 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	F 550		

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F 550	Continued From page 5 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 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. 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.	F 550		

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F 550	Continued From page 6 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 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. 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. 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. 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	F 550		

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time, and resident aware of new smoking restrictions and consequences of unsafe smoking practices.

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.

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

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F 550	Continued From page 8 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 resident to unit, and restrictions to be put in place for 6 months. 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. 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	F 550		

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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 area and observed he could smoke safel. 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.

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.

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:
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

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floor north lounge. All other units have been designated as completely non-smoking.
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 permitted on the dining patio on the south side of the canteen.
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.

As of 6/27/19, the facility smoking policy did not require residents to store smoking materials with the facility.

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

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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. 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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 12 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 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. 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. 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	F 550		

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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 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.

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.

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

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F 550	Continued From page 14 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. 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 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. 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. 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. At 4:50 p.m. the notes recorded the resident received directive he was not to bum or purchase smoking materials from other residents. On 7/9/19 at 12:58 p.m. the Progress Note	F 550		

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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.
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 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.
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

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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 smoking. They told the resident they didn't want to have to do that but he needed to comply with the smoking rules.

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.

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

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F 550	Continued From page 17 3 times to ensure safety with ashing and told to wear a smoke guard at all times when smoking. 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 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. 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. 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.	F 550		

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F 550	Continued From page 18 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. 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 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. 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. On 9/13/19 at 3:08 p.m., the Progress Note	F 550		

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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 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.

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.

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.

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

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F 550	Continued From page 20 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 continue to complete room searches as previously. The resident voiced understanding of his final warning. 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. 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. On 6/19/19 you were given a copy of the updated smoking areas and verbalized understanding. 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.	F 550		

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F 550	Continued From page 21 An intervention was put into place to have all smoking materials kept and issued by nursing staff to keep you safe. 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. 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. 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. 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. On 8/26/19 you were observed ashing your cigarette on yourself and the smoke room floor. On 8/27/19 you were issued a 1st strike, following the 8/26 incident per facility protocol. 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. 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. 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.	F 550		

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F 550	Continued From page 22 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. 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 mental health services. Please give serious consideration to these resources. 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. Please see me if you have questions or concerns, Sincerely, Commandant. 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. 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	F 550		

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F 550	Continued From page 23 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. 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. 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. 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	F 550		

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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:

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.

b. Voluntary ban from Meskwaki Casino.

c. Voluntary total funds restriction.

d. No casino or shopping trips with facility recreation.

e. Participating in the smoking cessation support group and/or individual psychotherapy with mental health.

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

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F 550	Continued From page 25 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. The facility letter dated 10/25/19, signed by Resident #5 and Staff G, documented the following: After repeated violations of the smoking policy, I, Resident #5, agree to the following in order to remain a resident at the facility: a. I will abstain from smoking or having cigarettes or other smoking materials in my possession. 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. c. I will request a voluntary ban from Meskwaki Casino. d. I will request a voluntary total funds restriction. Any requests for funds will go through my social worker. e. I will only go on shopping trips with 1:1 staff or volunteer and will not go on Casino trips with facility recreation. f. I will participate in the smoking cessation support group and/or individual psychotherapy with mental health to assist me in successful smoking cessation. 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	F 550		

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violations of the smoking policy will result in my being discharged from the facility.
My signature signifies agreement with the above.

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 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.

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

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(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.

On 11/8/19 at 11:08 a.m. the Progress Note documented an order for buproprion (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.

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 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.

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

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F 550	Continued From page 28 smoking. The resident continued to experience cravings to use cigarettes. 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 stated they worried he would leave to the casino but felt he could leave the unit without smoking. Observation on 1/2/20 at 1:06 p.m. revealed the interior smoking room in the Mailoy 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	F 550		

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F 550	Continued From page 29 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. The book contained the following information: Resident #5, M2N - Not allowed to smoke 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 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.	F 550		

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F 550	Continued From page 30 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 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	F 550		

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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 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.
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.

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F 550	Continued From page 32 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 (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	F 550		

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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 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

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F 550	Continued From page 34 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. 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 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 it 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	F 550		

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F 550	Continued From page 35 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. 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 (weakness on 1 side of the body), depression, and PTSD (Post Traumatic Stress Disorder). 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. The care plan problem area updated 10/29/19 identified difficulty speaking and expressing himself due to effects of stroke in 2012. 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	F 550		

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F 550	Continued From page 36 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. On 2/27/19, the care plan updated to include the resident signed the Smoking Safety Expectations form annually. 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. 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 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. 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	F 550		

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F 550	Continued From page 37 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 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. 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	F 550		

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F 550	Continued From page 38 assessment (lit, smoked, and extinguished in proper receptacle). 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. 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 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	F 550		

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F 550	Continued From page 39 smoking violation could result in immediate/permanent loss of smoking. 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. 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. 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 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. 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	F 550		

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F 550	Continued From page 40 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. 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. 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. On 10/30/19 at 11:53 a.m. the Progress Note documented when Resident #1 at the smoke	F 550		

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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.

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.

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.

On 11/26/19 at 10:09 a.m., the Progress Note documented while staff assisted Resident #1 on

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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.

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.

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

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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 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

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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 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

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F 550	Continued From page 45 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. 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. At 11:29 a.m., observation revealed Resident #1 self-propelled his wheelchair out of his room towards the commons area hallway with left arm and leg able to maneuver around corners without difficulty, independently. 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	F 550		

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F 550	Continued From page 46 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. 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. 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 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	F 550		

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F 550	Continued From page 47 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. The goal evaluation dated 12/12/19 documented Resident #7 safe and fee 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. 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. 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 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. The Smoking Assessment signed 6/13/19 documented the following: Question (Q) 1 - resident smoked	F 550		

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F 550	Continued From page 48 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 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. 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	F 550		

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F 550	Continued From page 49 reassessed by the care team. 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. 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. 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. 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. 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	F 550		

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#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).

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.

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 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.

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

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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.

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; 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.

On 9/11/19 at 2:20 p.m., the Progress Note documented a quarterly Social Worker MDS

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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.

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

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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.

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.

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.

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 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.

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F 550	Continued From page 54 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 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	F 550		

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privileges would be revoked.
Staff A and Staff B confirmed the 1 and done policy with no second chances given.

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.
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.

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.

Review of the clinical record revealed no other incident reports related to smoking documented prior to 1/1/20.

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

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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.

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 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

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F 550	Continued From page 57 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. 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. 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 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	F 550		

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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.

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.

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 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

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F 550	Continued From page 59 #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 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	F 550		

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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 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

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F 550	Continued From page 61 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. 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 locomotion on/off the unit. The MDS documented diagnoses that included schizophrenia, PTSD, and nicotine dependence with chewing tobacco.	F 550		

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F 550	Continued From page 62 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. 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. The care plan did not address the resident's use of smokeless/chewing tobacco. 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.	F 550		

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F 550	Continued From page 63 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. 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 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	F 550		

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room and Resident #14 spoke up to the Senator complaining about administration. Staff J wrote Resident #14 then returned to the unit.
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.

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 think he could chew there, just the smoke room. Resident #14 started yelling, oh yes he could chew wherever he wanted to. Staff K

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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.

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.

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.

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 that. The note documented the resident in wheelchair

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at that time with mild hand tremors, no head tremors.

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.

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

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in the smoke room and 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.

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,

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Staff L, told the resident to go downstairs to chew. Staff J 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

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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 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

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F 550	Continued From page 70 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. 5. The MDS assessment dated 711/19 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. 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	F 550		

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F 550	Continued From page 71 resident from smoking such as visiting, 1:1 time, take to canteen for snack, take outside if whether is appropriate, offer activities such as games/cards, movies, music, etc. 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. 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. 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	F 550		

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F 550	Continued From page 72 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. 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. 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. The smoking policy form #475-2082, dated as revised 10/17, titled Safety Expectations for Resident Smoking, signed by Resident #8 on	F 550		

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F 550	Continued From page 73 3/8/19 included the following: a. Smoking is not permitted in resident rooms. 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, 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. 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 =	F 550		

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F 550	Continued From page 74 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 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. 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. 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. The Smoking Assessment signed 7/18/19 documented identical information for questions	F 550		

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F 550	Continued From page 75 Q1 thru Q13 as 6/20/19 assessment and the resident status remained Unsupervised smoker. The Comments section recorded identical information as well. 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 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. On 7/18/19 at 10:26 a.m. the Progress Note documented a Nursing Head-to-Toe Assessment. 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	F 550		

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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 depression or anxiety; and received medications for depression with history of suicide attempt, insomnia.

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.
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 rational for the change as unsafe smoking.
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.
Review of the clinical record lacked documentation the resident or the resident representative/guardian notified and/or gave consent for nicotine patch.
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

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resident during his shower and order received to reapply the patch in the morning.
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 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.
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

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IOWA VETERANS HOME	1301 SUMMIT MARSHALLTOWN, IA 50158

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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.
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 informed he could not smoke to which he replied that is bullshit.
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.
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 8/9/19 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.
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

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F 550	Continued From page 79 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	F 550		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656	F 656 Correction date February 14, 2020 Current residents who smoke or use smokeless products will have care plans reviewed and updated to include safe use. Residents who wish to stop smoking will have care plans reviewed to ensure support for smoking cessation is included. All residents will have their care plans reviewed and updated on an ongoing basis. Completion date: February 14, 2020 Responsible party: AON	

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rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, observation, resident interview, family interview, and staff interview, the facility failed to ensure a comprehensive care plan developed to address a resident no longer allowed to smoke (Resident #1) and a resident who used smokeless tobacco (Resident #14); out of 13 residents reviewed for comprehensive care plans. The facility reported a census of 428 residents.

Findings include:

1. The Minimum Data Set (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

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F 656	Continued From page 81 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 (weakness on 1 side of the body), depression, and PTSD (Post Traumatic Stress Disorder). The care plan problem area updated 10/29/19 identified difficulty speaking and expressing himself due to effects of stroke in 2012. 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. On 2/27/19, the care plan updated to include the resident signed the Smoking Safety Expectations form annually. 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. 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 felt smoking the only thing the resident had left to enjoy, the SW	F 656		

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(Social Worker) gave appropriate information about the new smoking rules of supervised smoking indoors only.

The Smoking Assessment signed 10/29/19 documented the resident 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.

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.

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.

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 stood at a cart with drawers and a book on the

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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.

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 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 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 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.

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

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F 656	Continued From page 84 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. The care plan contained no other documentation to indicate the resident no longer allowed to smoke. 2. 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 locomotion on/off the unit. The MDS documented diagnoses that included schizophrenia, PTSD, and nicotine dependence with chewing tobacco. 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. 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.	F 656		

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F 656	Continued From page 85 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. 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. 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. 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 recorded Staff L, RTW, seen the resident put dip of chew in his mouth and told him she didn't 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	F 656		

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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.

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.

On 12/16/19 at 4:16 p.m., the Progress Note documented by Staff M, Social Worker, 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.

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 that. The note documented the resident in wheelchair

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at that time with mild hand tremors, no head tremors.

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.

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 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 stated Staff L then called the supervisor who said the resident could chew anywhere. Staff K reported Resident #14 upset. 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 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.

In an interview on 1/16/20 at 8:40 a.m. Staff J reported 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

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F 656	Continued From page 88 allowed to keep it themselves. 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 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 asked who told him that. The comprehensive care plan failed to address the resident's use of smokeless/chewing tobacco, the possibility interactions with medications with the use of chewing tobacco, or inform staff where the resident allowed to chew.	F 656		