STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355034	A. BUILDING _____ B. WING _____	09/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIOGA MEDICAL CENTER LTC	810 N WELO ST TIOGA, ND 58852

(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 For the standard Medicare/Medicaid recertification survey started on September 17, 2012 and completed on September 19, 2012, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review. The sample included ten (10) additional residents to verify specific concerns during the survey.	F 000		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility failed to provide monitoring, tracking and trending, and develop interventions individualized to specific resident needs for 3 of 3 sampled residents (Resident #1, #2, and #6) identified by the facility as experiencing behaviors, including aggressive and wandering behaviors. The facility failed to: 1. Implement the facility's own policy to identify residents and/or situations with potential for the occurrence of injury, prevent resident to resident injury, and protect residents from recurring resident to resident injury. 2. Adequately assess resident behaviors, including monitoring for patterns/trends, causative factors, including time, place, persons involved, happenings prior to and at the time of the	F 250	1. The care plans on residents #1, #2, and #6 were updated with specific individualized approaches and interventions. A behavior tracking form was started to track implementations of interventions, and if they were effective. Also on the tracking form includes time, place, persons involved and prior happening for behaviors. 2. All residents have the potential to be affected by inadequate behavior monitoring, whether the behavior is happening to them or others. 3. Behavior tracking form F250 and the resident behavior policy were reviewed at the 10/26/12 mandatory nursing staff meeting. This information is posted as required reading for all staff unable to attend the meeting. Staff was educated on filling out the first section of form F250. The form will be taken to the weekly/bi-weekly risk (cont. on page 2)	10/26/12

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

Randall K. Pederson | President/CEO | 10/26/12

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 250	Continued From page 1 behavior, and implement appropriate interventions to prevent behaviors from escalating. 3. Monitor the effectiveness of interventions and revise interventions as appropriate. 4. Implement an interdisciplinary approach to address behaviors which have the potential to result in resident to resident altercation. Failure to adequately assess and monitor residents' behaviors and implement effective interventions or evaluate current interventions to prevent further behaviors resulted in other residents being victims of physical, verbal, and mental abuse. Findings include: The facility policy titled "Resident Behavior," revised July 2011, stated, "STANDARDS: . . . 2. All problem behavioral incidents . . . will result in thorough review for potential causes. Occurrences where there is harm or potential harm to others or abuse will result in immediate intervention. . . . All assessments will be documented, the care plan revised and staff instructed on practical care measures. . . . BEHAVIORAL INTERVENTION GUIDELINES: . . . 5. Those behaviors selected to be remedied through utilization of behavior management techniques must be related to the resident's long and short term goals as reflected in his overall plan of care, and all appropriate staff trained to insure consistency of approaches. . . . 10. Interdisciplinary progress notes shall reflect the success of intervention and change in inappropriate behaviors. . . ." - Review of Resident #2's medical record	F 250	(cont. from page 1) management meetings for review. Further assessing, implementation and care planning will be done at that time. The resident behavior policy was updated to reflect current practices. 4. A QI tool has been implemented to monitor that form F250 is completed and care planned. The DON/designee will do QI weekly audits x4, then monthly x5, unless determined otherwise by the QI committee. The QI will be brought to the QI meetings monthly.	

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F 250	Continued From page 2	F 250		

occurred during all days of survey. Diagnoses included Alzheimer's dementia, confusion, and history of multiple cerebrovascular accidents (CVA). An annual MDS, dated 08/09/12, identified a BIMs score of 3 (severely impaired), continuous inattention/disorganized thinking, and wandering on a daily basis. A MDS and Social Services Note, dated 08/09/12, stated, "Behaviors: Triggered due to her physical and verbal symptoms that occur. She did pinch another resident . . . She also will swear at others, take food off of their trays. . . . She continues to wander aimlessly and needs to be redirected. At times she is easily redirected, at other times not . . . There has been nothing documented nor verbal information of things that will trigger before an issue arises . . ." The Nursing Assessment Summary, dated 08/08/12, further stated, ". . . The resident wandered daily, wandering significantly intruded on the privacy or activities of others. . . ."

A summary of Resident #2's Progress Notes and Vitals Detail Reports, dated 10/03/11 - 08/23/12, indicated the following behaviors:
* yelling at another resident
* hitting/striking out at other residents
* grabbing/pinching others, causing pain to one resident's wrist
* grabbing at other residents' walkers
* blocking another resident from exiting the area
* pushing other residents
* wandering hallways and into other residents' rooms
* removing items from other residents' room

Review of Resident #2's current plan of care failed to identify behaviors as a problem area.

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F 250	Continued From page 3 The care plan did state, "Problem: Alterations in cognition . . . Approach: . . . If agitated/restless, redirect to a more quiet, less stimulus area. . . . Problem: Need for environmental stimulation . . . Approach: . . . Redirect out of others rooms, if takes thing have her give back and redirect to her own room. . . . Problem: Potential for falls . . . Approach: . . . Resident to have wanderguard . . ." During an interview on the afternoon of 09/18/12, when asked what individualized interventions had been put in place to address Resident #2's behaviors, a managerial social services staff member (#1) stated, "She doesn't have a care plan?" Failure of the facility to assess the precipitating factors leading up to, or resulting in Resident #2's behaviors and wandering, develop and implement effective interventions, as well as revise them as necessary; resulted in numerous altercations with other residents and in Resident #2 wandering throughout the facility and into other residents' rooms. (See F309 for further details.) - Review of Resident #1's medical record occurred during all days of survey. Diagnoses included Alzheimer's dementia and subdural hematoma. An annual MDS, dated 08/18/12, identified a BIMs score of 8 (moderately impaired), and verbal behavioral symptoms directed towards and impacting others. A MDS and Social Services Note, dated 08/18/12, stated, "Behaviors: . . . He has verbally become threatening and screaming and shouting at others	F 250		

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and this did have a significant impact on others. Other residents do become irritated with him. . . . This has significantly intruded on the privacy of others . . . He has become worse in these behaviors. . . ." The Nursing Assessment Summary, dated 08/18/12, further stated, ". . . Impact of behavioral symptoms on others: Significantly intruded on the privacy or activities of others, significantly disrupted care or living environment. . . ."

Review of Resident #1's Progress Notes, dated 03/03/12 - 09/02/12, indicated the following behaviors:

* 03/03/12, ". . . very upset and states, 'that man [Resident #19] comes in my room again and {starts swinging his fists}, this is what will happen to him.' . . . States, 'he better not come here again.' . . . is very upset after a confused resident entered his room. States 'He better stay out!' Shouts at confused resident to 'Go away!' Chases confused resident out of room and down the hallway. . . ."
* 03/17/12, ". . . is very rude at times to other residents thinks he's in total control of everything [and] often tells his roommate [Resident #9] what to do, also becomes easily upset with [Resident #19] when he is so very confused."
* 03/19/12, ". . . has become impatient with other residents and is very verbally short with them if [Resident #1] doesn't like them or they are confused. . . ."
* 03/29/12, ". . . has been making rude comments towards . . . residents. . . . Resident is also bossy to roommate, and is very short tempered with confused residents. . . ."
* 03/30/12, ". . . has been making comments to roommate about roommates [sic] weight . . . and

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then asked roommate, 'Piss you off?' . . ."
* 04/16/12, ". . . continues to be rude to others verbally telling them exactly what he thinks of them (very hurtful to others). . . . tells his roommate [Resident #9] what to do and when . . . will wake roommate up at 3:00 a.m., and tell him to stop snoring and get up for the day . . . is rude at times [and] very bossey [sic] to roommate . . ."
* 04/24/12, ". . . upset with roommate when doing exercises that he is not doing them correctly. . . ."
* 04/25/12, ". . . was very confused [and] irritated this forenoon . . . ranting at other resident's [sic] . . ."
* 05/25/12, ". . . upset . . . that another resident was sitting in his spot. Made some rude comments . . ."
* 06/02/12, ". . . has been rude to roommate. . . ."
* 06/08/12, ". . . snappy with another [unidentified] resident . . ."
* 06/14/12, ". . . became upset with another resident . . . as [Resident #20] was making moaning noises and [Resident #1] wanted this resident removed from the area right away. . . ."
* 06/15/12, ". . . upset with his roommate . . . I did tell him he could not hit his roommate on the head with a rolled up magazine no matter how lightly he hit his head. . . . became angry with his roommate. . . ."
* 07/07/12, ". . . Tenant . . . At LTC [long term care] facility to have coffee with resident . . . became angry as tenant sat in his chair . . . hollered loudly at tenant and vice versa. . . ."
* 07/26/12, ". . . was yelling at another [unidentified] resident . . ."
* 08/06/12, ". . . does tell his roommate what to do most of the time. His roommate will get angry at him at times. . ."
* 08/22/12, ". . . is very short tempered and has a

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F 250	Continued From page 6 sharp voice that sounds like he is hollaring [sic] or mad at tothers [sic]. He does 'bully' others especially his roommate. Bullying demonstrated by his loud voice telling roommate or others 'to put hands higher in the air during exercises, don't do it like that, that isn't how you do it, your [sic] stupid, you don't know nothing' . . . he has put his fist into others [sic] face threatening. . . . he has significantly disrupted the privacy and living environment of others. . . ." * 08/23/12, ". . . Makes rude comments and gives rough sounding directions to others espicially [sic] to his roommate [sic]. He does hurt others feelings so does have a negative effect on others. . . ." * 08/27/12, ". . . continues to be rude to others and will use a loud, rude voice. . . ." * 08/30/12, ". . . [Name of a different facility] . . . are not able to accept him . . . due to demonstrated behavior issues. . . ." * 09/02/12, ". . . was conversing with fellow female resident when he began to make lewd comments . . . continued on and started shouting the lewd comments . . ." Review of Resident #1's current plan of care failed to identify behaviors as a problem area. The care plan did state, "Problem: Get to know me . . . Approach: . . . No patience for any cognitively declined people, Makes rude remarks to others . . . Remind [Resident #1] of rude comment(s) [and] how it hurt others at the time. . . ." During an interview on the afternoon of 09/18/12, when asked what individualized interventions had been put in place to address Resident #1's behaviors, a managerial social services staff	F 250		

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F 250	Continued From page 7 member (#1) stated, "There's no careplan?" Failure of the facility to assess the precipitating factors leading up to, or resulting in Resident #1's behaviors, develop and implement effective interventions, as well as revise them as necessary; resulted in numerous altercations with other residents. - Review of Resident #6's medical record occurred during all days of survey. Diagnoses included hallucinations, anxiety, Parkinson dementia, and depression. An admission MDS, dated 04/02/12, identified a Brief Interview for Mental Status (BIMs) score of 12 (cognitively intact), displayed a fluctuating altered level of conscious, moderate depression and rejection of care. A quarterly MDS, dated 06/29/12, identified a BIMs score of 12, disorganized thinking, a moderate level of depression, hallucinations and delusions, and verbal behavior. A MDS and Social Services Note, dated 04/02/12, stated, "[Resident's name] was at [name of the hospital] . . . due to behaviors demonstrated by agitation, hallucinations, delusion, verbal and physical behaviors. The physical behaviors were beginning to be demonstrated to other residents and staff; residents had become very leery and frightened of [resident's name]. Due to her psychosis, staff were not able to control any type of behaviors because one moment she would be fine and the next she would not. . . . she will be continuing ECT [Electroconvulsive Therapy] . . . and will be monitored by [name of the hospital] . . . "	F 250		

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F 250	Continued From page 8 A summary of Resident #6's Progress Notes for the months of May, June, July, August, and September 2012, indicated the following behaviors: - refusing medications and distrust regarding her medications and the staff - agitated, weepy, staying in room, - episodes of being paranoid and suspicious - angry at staff, and refusing assessments by the nurses A social services note, dated 08/06/12, stated, ". . . continues to have eposides [sic] of delusions, paranoid and sees/hears hallucinations. She is taking antipsychotic medications and being monitored by [physician's name] . . . continues to have ECT treatments . . . smiling more and coming out of her room more for activities and meals . . ." Review of Resident #6's current plan of care lacked information about behaviors, hallucinations, anxiety or depression experienced by the resident or information regarding the continuation of ECT treatments and possible side effects. Failure of the facility to assess the precipitating factors leading up to, or resulting in Resident #6's behaviors, develop and implement effective interventions, as well as revise them as necessary, may have resulted in the resident requiring hospitalization.	F 250		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309	1. The care plan on resident #2 has been updated with specific individualized approaches and interventions. (cont. on page 10)	10/26/12

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F 309	Continued From page 9 provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services to manage behavioral and psychological symptoms of dementia (BPSD) for 1 of 3 sampled residents (Resident #2) identified by the facility with behaviors and a diagnosis of dementia. The failure to identify target BPSD, assess the reason/causative factor(s) for the behaviors, implement appropriate individualized interventions (including non-pharmacological interventions) and establish accurate on-going monitoring of the behaviors has the potential for the residents not to obtain their highest practicable physical, mental, and psychosocial well-being. Findings include: The facility policy titled "Resident Behavior," revised July 2011, stated, "STANDARDS: . . . 2. All problem behavioral incidents . . . will result in thorough review for potential causes. Occurrences where there is harm or potential harm to others or abuse will result in immediate intervention. . . . All assessments will be documented, the care plan revised and staff instructed on practical care measures. . . .	F 309	(cont. from page 9) A behavior tracking form was started to track implementations of interventions and if they were effective. Also on the tracking form includes abuse to others and self. 2. All residents have the potential to not have the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 3. Behavior tracking form F250 and the resident behavior policy were reviewed at the 10/26/12 mandatory nursing staff meeting. This information is posted as required reading for all staff unable to attend the meeting. Staff were educated on filling out the first section of Form F250. The form will be taken to the weekly/bi-weekly risk management meetings for review. Further assessing, implementation and care planning will be completed at that time. The resident behavior policy was updated to reflect current practices. 4. A QA/QI tool was implemented to monitor that form F250 is completed and care planned. The DON/designee will do QI weekly audits x4, then monthly x5, (cont. on page 11)	

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F 309	Continued From page 10 BEHAVIORAL INTERVENTION GUIDELINES: . . . 5. Those behaviors selected to be remedied through utilization of behavior management techniques must be related to the resident's long and short term goals as reflected in his overall plan of care, and all appropriate staff trained to insure consistency of approaches. . . . 10. Interdisciplinary progress notes shall reflect the success of intervention and change in inappropriate behaviors. . . ." - Review of Resident #2's medical record occurred during all days of survey. Diagnoses included Alzheimer's dementia, confusion, and history of multiple cerebrovascular accidents (CVA). An annual MDS, dated 08/09/12, identified a BIMs score of 3 (severely impaired), continuous inattention/disorganized thinking, and wandering on a daily basis. A MDS and Social Services Note, dated 08/09/12, stated, "Behaviors: Triggered due to her physical and verbal symptoms that occur. She did pinch another resident . . . She also will swear at others, take food off of their trays. . . . She continues to wander aimlessly and needs to be redirected. At times she is easily redirected, at other times not . . . There has been nothing documented nor verbal information of things that will trigger before an issue arises . . ." The Nursing Assessment Summary, dated 08/08/12, further stated, ". . . The resident wandered daily, wandering significantly intruded on the privacy or activities of others. . . ." Review of Resident #2's current plan of care failed to identify behaviors as a problem area. The care plan did state, "Problem: Alterations in cognition . . . Approach: . . . If agitated/restless,	F 309	(cont. from page 10) unless determined otherwise by the QI committee. The QI will be brought to the QI meetings monthly.	

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redirect to a more quiet, less stimulus area. . . . Problem: Need for environmental stimulation . . . Approach: . . . Redirect out of others rooms, if takes thing have her give back and redirect to her own room. . . . Problem: Potential for falls . . . Approach: . . . Resident to have wanderguard . . ."

Medications taken by Resident #2's include:
* Seroquel 25 mg (an antipsychotic) daily, started on 10/15/11
* Ativan 1 mg (an anxiety) tid prn (as needed), started on 09/02/11

Review of Resident #2's Progress Notes and Vitals Detail Reports, dated 10/03/11 - 08/23/12, indicated the following behaviors:
* 10/03/11, ". . . hit out at [Resident #13] when [Resident #13] requested that [Resident #2] move . . ."
* 10/15/11, ". . . wanders daily . . ."
* 11/21/11, ". . . aggigated [sic] during the night, up at 0030 wandering hallways and into patient's rooms [sic] . . . Was back up at 0330 . . . and remains aggitated [sic] attempting to go into patient rooms. . . ."
* 11/23/11, ". . . does get up during the night and will wander into other rooms. . . . did grab [Resident 14's] wrist during evening meal and it caused pain to that resident. . . ."
* 11/26/11, "CNA reported that she witnessed [Resident #2] strike out at [Resident #15] . . ."
* 11/30/11, ". . . did strike out at another resident [#15] . . ."
* 12/04/11, ". . . became crabbey [sic] [and] irritable at another [unidentified] resident . . ."
* 12/06/11, ". . . up again wandering. . . ."
* 12/07/11, ". . . became slightly agitated at

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	355034	A. BUILDING _____ B. WING _____	09/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIOGA MEDICAL CENTER LTC	810 N WELO ST TIOGA, ND 58852

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F 309	Continued From page 12 another [unidentified] resident . . ." * 12/17/11, ". . . was wandering into [four first names of residents] room [sic] . . . took a sweater . . ." * 12/19/11, ". . . started to wander into other residents [sic] rooms and did take a sweater. . . ." * 12/27/11, ". . . she was not allowing [Resident #16] to go to her designated sitting area . . . she [Resident #2] was blocking the way and slowly edging her [Resident #16] back. . . ." * 12/29/11, ". . . sitting by her roommate [Resident #16] . . . and kept telling roommate to close her mouth and would put her hand up to roommate's mouth . . . arguing and grabbed her roommates [sic] walker and trying to push her roommate backwards out of the door and trying to shut the bedroom door. Resident [#2] said she doesn't like her roommate. . . . Another resident [#17], was walking by the resident [#2] and asked her a question, and [Resident #2] attempted to swing at [Resident #17]. . . ." * 01/15/12, ". . . wandering the halls . . ." * 01/17/12, ". . . Going in patients [sic] rooms, took other res. shoe and put it on . . . Informed res. [#2] that everyone was in bed. . . . ." * 01/28/12, ". . . walking the halls . . . One of the other residents was reaching for something . . . and resident [#2] slapt [sic] their [sic] hand away . . ." * 02/15/12, ". . . likes to irritate other residents at times . . . trying to take candy from another [unidentified] residents [sic] basket on her walker, the other resident and [Resident #2] started yelling at each other. . . . [Resident #2] told [Resident #16] to sit back down and grabbed at [Resident #16's] walker. . . ." * 02/17/12, ". . . wandering aimlessly . . ." * 02/18/12, ". . . Acted rough with another	F 309		

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F 309	Continued From page 13 [unidentified] resident, grabbing her by the arm . . ." * 02/19/12, ". . . wandering into other resident's rooms [sic]. . . ." * 02/21/12, ". . . wandering . . ." * 02/22/12, ". . . went into other resident's rooms [sic]. . . ." * 03/18/12, ". . . redirecting her from other residents' rooms . . ." * 03/23/12, ". . . continues to wander during night. Staff continues to redirect out of others [sic] rooms . . ." * 06/13/12, ". . . struck out and grabbed and pushed . . . as [Resident #16] was leaning forward . . ." * 06/19/12, ". . . has become more agitated.and [sic] more confused when wandering. . . . has hit out and physically pinched [Resident #18] . . ." * 07/11/12, ". . . becoming very aggitated . . . trying to get all the residents . . . to leave . . ." * 07/22/12, ". . . wandering within the facility this evening, has been in other resident's [sic] rooms . . ." * 08/06/12, ". . . taking food off others [sic] trays and getting irate at other REsidents. . . . did wander in hallways and into other rooms during the night . . ." * 08/10/12, "Keeps taking blankets away from other residents." * 08/23/12, ". . . wandering around . . ." During an interview on the afternoon of 09/18/12, when asked what individualized interventions had been put in place to address Resident #2's behaviors, a managerial social services staff member (#1) stated, "She doesn't have a care plan?"	F 309		

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F 309	Continued From page 14 Failure of the facility to assess the precipitating factors leading up to, or resulting in Resident #2's behaviors/wandering and develop and implement effective interventions to minimize/decrease her behavior symptoms, resulted in numerous altercations with other residents.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to determine a resident's ability to safely smoke without supervision for 1 of 1 sampled resident (Resident #4) who smoked independently in an area outside the building. Failure to assess Resident #4's ability to safely smoke independently, and communicate the facility policy to all staff placed this resident and all facility residents, staff, and visitors at risk of injury. Findings include: Review of the facility policy titled "Smoking Policy & Procedure" occurred on 09/19/12. This undated policy, stated, "NO SMOKING POLICY . . . 1. Use of tobacco material will be prohibited throughout	F 323	1. A resident smoking policy was created and implemented. A smoking assessment form was started for any resident who smokes. A smoking assessment was completed on resident #4 and his care plan was updated according to his individualized smoking plan. 2. All residents, staff and visitors have the potential to be affected by not having a smoking assessment completed and individualized smoking care plan on all residents who smoke. 3. A policy has been established that residents who smoke will have a smoking assessment and individualized smoking care plan completed. A mandatory educational staff meeting was held 10/26/12. The smoking policy, smoking assessment and smoking care plan were reviewed. Staff was re-educated on lighters/ cigarettes to be kept at the nurses station. 4. A QI tool was implemented to monitor that all residents who smoke have a smoking assessment completed and a smoking care (cont. on page 16)	10/26/12

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F 323	Continued From page 15 the hospital, long term care center, and clinic buildings by staff, patients and visitors . . . 2. a. Gazebo/Courtyard - This area is designed for all employees . . . 5. Residents of the Long Term Care facility who were admitted prior to January 1, 1992 will be permitted to smoke or use smokeless tobacco in a designated area. Residents admitted after January 1, 1992 will abide by the . . . policy. . . . " - An observation on 09/17/12 at 4:05 p.m., showed Resident #4 wheeled himself to the nurses station, received a cigarette from the nurse, wheeled himself to the door leading out to the gazebo/courtyard, and once outside lit and smoked his cigarette. Review of Resident #4's medical record occurred during all days of survey and identified an admission date in June 2012. Diagnoses include intellectual disability, difficulty walking, and blindness in one eye. Review of Minimum Data Sets (MDSs) dated 06/11/12 and 09/01/12 identified the Resident as cognitively intact. Review of Resident #4's most current care plan identified, "Problem, SMOKING IN NON-SMOKING FACILITY, Goal * To smoke only in gazebo, Approaches . . . *REMIND RESIDENT TO DISPOSE OF CIGARETTES IN PROPER RECIPROCAL *ASSIST RESIDENT WITH OPENING THE GAZEBO DOOR TO GO OUTSIDE TO SMOKE WHEN NEEDED . . . " Review of Resident #4's progress notes stated the following: * 06/08/12, 9:01 a.m., ". . . He enjoys smoking. Cigarettes are kept at nurses station to avoid him	F 323	(cont. from page 15) plan initiated. The DON/designee is responsible for this monitoring. The DON/designee will do QI weekly audits x4, then monthly x5 months, unless determined otherwise by the QI committee. The QI monitoring will be brought to the QI meetings monthly.	

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F 323	Continued From page 16 smoking in the bathroom. His roommate has oxygen in room and [Resident's name] did smoke in bathroom in swing bed. . . ." * 06/13/12, 12:01 p.m., ". . . cigarettes are kept at the nurses station to insure [Resident's name] [sic] not lighting up where oxygen is being used. . . ." During a interview on the morning of 09/18/12, a facility staff nurse (#2) and social services staff member (#1) reported Resident #4's cigarettes are kept at the nurses station but were unclear as to the location of the lighter. During an interview on 09/18/12 at 9:00 a.m., social services staff member (#1), reported the facility does not do a smoking assessment. Failure of the facility to develop policies which describe the methods by which residents are deemed safe to smoke without supervision, and failure to complete an assessment of Resident #4's ability to safely smoke could result in injury to the resident.	F 323		