STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105461	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Brentwood	2333 N Brentwood Cir Lecanto, FL 34461

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 40559 Based on observation, interview, and record review, the facility failed to maintain a clean and homelike environment in one hall out of three main front hallways. Findings include: During an interview on 8/12/2024 at 11:09 AM, Resident #58 stated, Did you see the black stuff in the hallway on the ceiling, over there where they do Bingo. It should be cleaned off. During an observation on 8/12/2024 at 2:20 PM, the hallway between main dining room and 400 Hall had a water leak in a ceiling tile and black substance on upper support header. (Photographic evidence obtained) During an interview on 8/12/2024 at 2:45 PM, the Maintenance Director confirmed there was a leak in the roof above the hallway and stated it had been an issue for a while. During an interview on 8/13/2024 at 3:30 PM, Resident #35, Resident Council President, stated that Resident Council has reported concerns to management with water leaking and mold on the ceiling in the hallway outside of the main dining room for a long time. Review of the facility policy and procedure titled Maintenance dated 11/30/2014 and reviewed on 1/23/2024 showed it read, Policy: The facility's physical plant and equipment will be maintained through a program of preventive maintenance and prompt action to identify areas/ items in need of repair. Procedure . The Director of Environmental Services will perform daily rounds of the building to ensure the plant is free of hazards and in proper condition.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40559 Based on record review and interview, the facility failed to ensure assessments accurately reflected the resident's status for 1 of 4 residents reviewed for discharge status (Resident #102), 1 of 4 residents reviewed for nutrition (Resident #2), and 1 of 5 residents reviewed for falls (Resident #10). Findings include: 1. Review of Resident #102's admission record showed the resident was admitted to the facility on [DATE] and discharged on [DATE] to an Assisted Living Facility. Review of Resident #102's MDS (Minimum Data Set) discharge return not anticipated assessment dated [DATE] showed Section A2105- Discharge Status documented the resident was discharged to a short-term general hospital. Review of Resident #102's progress note titled Discharge Summary and dated 6/25/2024 showed it read, Pt [Patient] discharged to ALF [Assisted Living Facility]. Pick up with ALF staff via wheelchair. discharged with personal belongings, discharge papers and remaining prednisolone eye drops and insulin pen. During an interview on 8/13/2024 at 12:27 PM, Staff A, MDS Coordinator, verified that Resident #102 was coded as discharging to short-term general hospital. 46523 2. Review of Resident #2's physician order dated 2/26/2024 showed it read, CCD NAS [Controlled Carbohydrate Diet No Added Salt] diet, Regular Texture, regular/thin liquids consistency, all meats chopped. Review of Resident #2's quarterly MDS dated [DATE] showed it read, K0520. Nutritional Approaches . C. Mechanically altered diet require change in texture of food or liquids (e.g. pureed food, thickened liquids) . 3. While a Resident: No. During an interview on 8/14/2024 at 10:25 AM, Staff A, MDS Coordinator, stated, [Resident #2's name] had orders for all meats chopped. The mechanically altered diet should have been coded yes. 3. Review of Resident #10's admission record showed the resident was most recently admitted on [DATE] with the diagnoses including other lack of coordination, unspecified dementia, muscle weakness, difficulty in walking, other seizures, restlessness and agitation, and cognitive communication deficit. During an observation on 8/13/2024 at 8:24 AM, Resident #10 was lying in bed with bed position at the lowest level and a sign on the closet door that read, call don't fall. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #10's annual MDS dated [DATE] showed the resident did not have any falls since admission or prior to assessment under Section J1800. Review of Resident #10's progress note dated 4/25/2024 showed it read, Discussed fall that occurred on 4/24/2024 @ 515PM [at 5:15 PM]. Resident was found on the floor in her room. Resident stated that she was getting up to walk and fell . Bump noted to top of scalp. MD [Medical Doctor] and family notified. New intervention for lab review for AMS [Altered Mental Status]. Review of Resident #10's Change in Condition form dated 4/24/2024 showed it read, Situation: Fall without injury. Review of Resident #10's care plan initiated on 5/24/2022 showed it read, [Resident #10's name] is at risk for falls r/t [related to] lack of coordination, other symptoms and signs involving cognitive functions and awareness and need for assistance with personal care. Review of Resident #10's care plan initiated on 12/11/2023 showed it read, [Resident #10's name] has actual fall-poor balance, unsteady gait r/t unspecified dementia, unspecify severity without behavioral, psychotic or mood disturbance, and anxiety, altered mental status, other lack of coordination, other symptoms and signs involving cognitive functions and awareness and need for assistance with personal care. During an interview on 8/14/2024 at 10:20 AM, Staff A, MDS Coordinator, stated, [Resident #10's name] is coded incorrectly. She did have fall prior to the assessment. Review of the facility policy and procedure titled MDS with the last review date of 1/23/2024 showed it read, Policy: The center conducts initial and periodic standardized, comprehensive and reproductive assessment no less than every three months for each resident including, but not limited to, the collection of data regarding functional status, strengths, weakness, and preferences using the federal and/or state required RAI. Procedure . Each person completing a section or portion of a section of the MDS signs the attestation statement indicating its accuracy.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15234 Based on record review and interview, the facility failed to ensure 2 of 3 residents reviewed for preadmission screening and resident review (PASRR), Resident #38 and Resident #22, were referred to the appropriate state designated authority for Level II PASRR evaluation and determination. Findings include: Review of Resident #38's admission record revealed the resident was admitted to the facility on [DATE] with diagnoses that included unspecified psychosis not due to a substance or known physiological condition (onset date 1/5/2022). Review of Resident #38's psychiatry progress note, date of service 6/24/2024, revealed the resident had diagnoses that included brief psychotic disorder. Review of Resident #38's Level I PASRR completed by the facility staff on 3/27/2024 failed to reveal documentation in Section 1: PASRR Screen Decision-Making A. MI [Mental Illness] or suspected MI (check all that apply) that Resident #38 had a diagnosis of psychotic disorder. Review of Section IV: PASRR Screen Completion. Individual may be admitted to a Nursing Facility (check one of the following) showed it read, No diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated. Level II PASRR evaluation not required. Review of Resident #22's admission record revealed the resident was initially admitted on [DATE] and most recently admitted on [DATE] with diagnoses that included pseudobulbar affect (onset date 7/9/2021), delusional disorders (onset date 5/11/2021) and unspecified psychosis not due to a substance or known physiological condition (onset date 1/14/2021). Review of Resident #22's psychiatry care plan note, date of service 6/10/2024, revealed the resident had diagnoses that included brief psychotic disorder and pseudobulbar affect. Review of Resident #22's Level I PASRR completed by the facility staff on 3/27/2024 failed to reveal documentation in Section 1: PASRR Screen Decision-Making A. MI or suspected MI (check all that apply) that Resident #2 had diagnoses of pseudobulbar affect, delusional disorders and psychotic disorder. Review of Section IV: PASRR Screen Completion. Individual may be admitted to a Nursing Facility (check one of the following) showed it read, No diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated. Level II PASRR evaluation not required. During an interview on 8/14/2204 at 12:35 PM, the Director of Nursing stated Resident #38's and Resident #22's PASRRs were not accurate, should include the residents' psychiatric diagnoses and needed to be corrected.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 49444 Based on observation, interview, and record review, the facility failed to ensure that residents received wound care treatment in accordance with professional standards of practice for 1 of 5 residents reviewed for skin conditions, Resident #85. Findings include: During an observation on 8/12/2024 at 8:55 AM, Resident #85 had a bandage placed over her forehead dated for 8/10/2024 with unreadable initials under the date. The bandage was not adhered to the head with all adhesive not touching the skin. The bandage was being held on with dried blood from the wound the bandage was covering. During an observation on 8/13/2024 at 10:15 AM, Resident #85 had a bandage placed over her forehead dated for 8/10/2024 with unreadable initials under the date. The bandage was not adhered to the head with all adhesive not touching the skin. The bandage was being held on with dried blood from the wound the bandage was covering. Review of Resident #85's physician order dated 1/2/2024 showed it read, Woundcare [Sic]-forehead open area cleanse with NS [Normal Saline], pat dry, cover with DPD [Dry Protectant Dressing] change daily and PRN [as needed]. Review of Resident #85's Treatment Administration Record (TAR) for August 2024 for wound care of the forehead showed no entry documented on 8/11/2024. During an interview on 8/14/2024 at 2:20 PM, the Director of Nursing (DON) stated, All physician orders need to be followed and if the nurse feels the order is not appropriate for the resident, she would be expected to contact the ordering physician to inform and obtain new orders for the wound care. During an interview on 8/14/2024 at 2:46 PM, Staff E, Wound Care Licensed Practical Nurse (LPN), stated, The dressing was not changed for the resident on 8/12/24. The wound care order would stay yellow on the charting system, and the nurse would know that the wound did not get the dressing changed and they would be obligated to complete the order. Review of the facility policy and procedure titled Dressing Change with the last review date of 1/23/2024 read, Policy: A clean dressing will applied [Sic] by a nurse to a wound as ordered to promote healing . Procedure . Apply treatment as order [Sic] and clean dressing.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 15234 Based on record review and interview, the facility failed to ensure the nurse staffing information was posted on a daily basis (Photographic evidence obtained). Findings include: Review of the displayed nurse staffing information document on Monday, 8/12/2024 at 5:59 AM, showed the nurse staffing information for Friday, 8/9/2024, was posted in the front lobby area of the facility. During an interview on 8/12/2024 at 7:00 AM, the Director of Nursing confirmed the posted nurse staffing information was not updated daily. He stated that the weekend supervisor was responsible to ensure the nurse staffing information was posted daily. During an interview on 8/14/2024 at 12:02 PM, the Director of Nursing stated the facility did not have a policy related to posting nurse staffing information. He stated the facility followed the federal regulation.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 46523 Based on record review and interview, the facility failed to ensure medical records were accurate for 1 of 5 residents reviewed for skin conditions, Resident #10, and 1 of 6 residents reviewed for medication administration, Resident #20. Findings include: 1. Review of Resident #10's physician order dated 6/19/2024 read, Woundcare [Sic]- sacrum apply house barrier cream three times a day and prn [as needed] . Order Status: Active . Start Date: 06/19/2024. Review of Resident #10's Medication Administration Record (MAR) for June 2024 for administration of house barrier cream on sacral wound showed no entries documented on 6/20/20204, 6/23/2024 and 6/24/2024 at 5:00 AM. Review of Resident #10's MAR for July 2024 for administration of house barrier cream on sacral wound showed no entries documented on 7/3/2024 at 1:00 PM, and on 7/7/2024, 7/10/2024, 7/13/2024, 7/21/2024, 7/24/2024, and 7/27/2024 at 5:00 AM. Review of Resident #10's MAR for August 2024 for administration of house barrier cream on sacral wound showed no entries documented on 8/1/2024, 8/4/2024, 8/7/2024, and 8/10/2024 at 5:00 AM. During an interview on 8/14/2024 at 1:45 PM, the Director of Nursing stated, The application of the barrier cream is being done, but the staff is not documenting it in the MAR. If the order is on the MAR, staff is expected to accurately document in the system. 2. Review of Resident #20's physician order dated 8/7/2024 showed it read, Midodrine HCl Oral Tablet 5 mg [milligram] (Midodrine HCl), Give 1 tablet by mouth every 8 hours related to orthostatic hypotension hold for BP >110 (blood pressure greater than 110). Do not administer past 6 PM. Review of Resident #20's MAR for August 2024 showed Midodrine HCl 5 mg was administered at 10:00 PM on 8/8/2024, 8/9/2024, 8/10/2024, and 8/13/2024. During an interview on 8/13/2024 at 9:42 AM, the Director of Nursing stated, [Resident #20's name] order was a transcription error. It will be updated. Review of the facility policy and procedure titled Documentation of Progress with the last review date of 1/23/2024 showed it read, Policy: Documentation of a resident's condition will provide an accurate and timely record of their progress taking into consideration their acuity and length of stay. Review of the facility policy and procedure titled Physician Orders with the last review date of 1/23/2024 showed it read, Policy: The center will ensure that Physician orders are appropriately and timely documented in the medical record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46523 Based on observation, interview, and record review, the facility failed to ensure staff performed hand hygiene while providing wound care, failed to implement enhanced barrier precautions, and failed to ensure staff used appropriate personal protective equipment while providing high contact care to the residents on enhanced barrier precautions to prevent possible spread of infection and communicable diseases. Findings include: 1. During an interview on 8/13/2024 at 8:45 AM, Staff E, Wound Care Licensed Practical Nurse (LPN), stated, [Resident #36's name] has a surgical wound on her abdomen and a pressure ulcer in her coccyx area, which she acquired during her last hospital stay. During an observation on 8/13/2024 at 9:03 AM, Staff E, Wound Care LPN, and Staff F, Certified Nursing Assistant (CNA), entered Resident #36's room. There was no enhanced barrier precautions sign or personal protective equipment outside of the resident room. Staff E and Staff F performed hand hygiene and donned gloves but did not don a gown. Staff F assisted Staff E with positioning Resident #36. The resident was turned on her side and a hydrocolloid dressing dated 8/10/2024 was observed. Staff E removed the dressing from coccyx and performed hand hygiene. Staff E prepared all wound care supplies and donned gloves and placed a barrier on the back of the resident's buttocks area. Staff E cleaned the open wound located in Resident #36's coccyx with gauze and normal saline. Without performing hand hygiene, Staff E patted dry the wound. Then, Staff E removed her gloves and performed hand hygiene. Staff E donned new pair of gloves and applied dressing to the coccyx area. Staff E and Staff F adjusted and placed briefs back on Resident #36. Without performing hand hygiene or removing the gloves used to dress the coccyx wound, Staff E continued to remove dressing located in the center of Resident #36's abdomen. Staff E removed gloves and washed her hands. Staff E donned new pair of gloves and applied iodine to Resident #36's surgical incision. Staff E preformed hand hygiene and donned new pair of gloves. Staff E applied new dressing to abdominal incision and readjusted Resident #36's briefs. Without performing hand hygiene or removing the gloves used to apply dressing to the abdominal incision, Staff E lifted Resident #36's left foot and applied skin prep to the left heel deep tissue injury wound. Review of Resident #36's physician orders dated 8/13/2024 showed it read, Isolation type-Enhanced Barrier Precautions d/t [due to] open wounds. 2. During an observation on 8/13/2024 at 10:14 AM, Staff E, Wound Care LPN, and Staff F, CNA, donned gloves and gown before entering Resident #3's room. Staff E preformed hand hygiene and removed old dressing and removed gloves. Without performing hand hygiene started to open the packets of gauze. Staff E donned new pair of gloves without hand hygiene and cleansed the wound in sacrum area with normal saline. Without performing hand hygiene, Staff E patted dry the cleaned area. Staff E removed gloves and performed hand hygiene and donned new pair of gloves. Staff E applied treatment and dressing to the sacral area. Staff E removed her gloves and performed hand hygiene and cleansed the wound on the right posterior thigh, which was not covered by a dressing. Staff E cleaned the wound and without hand hygiene, patted dry the area. Staff E removed her gloves and performed hand hygiene and applied dressing to the right posterior thigh. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #3's physician orders dated 8/13/2024 showed it read, Isolation type-Enhanced Barrier d/t wounds. During an interview on 8/13/2024 at 10:42 AM, Staff E, Wound Care LPN, stated, I should have done hand hygiene after cleaning the wound and when I removed my gloves [for Residents #3 and #36]. [Resident #36 name] does not have orders for enhanced barrier precaution that is why I didn't gown. I should have performed hand hygiene after cleaning the wound and also when removed the abdominal dressing after touching the briefs with the gloves. During an interview on 8/14/2024 at 11:04 AM, the Director of Nursing (DON) stated, Staff are expected to don gloves and gown when providing direct care to the residents who are on enhanced barrier precautions. [Resident #36's name] has enhanced barrier precautions due to her open wounds. Staff are expected to perform hand hygiene after cleaning a wound and moving onto another step and once they remove their gloves, they should perform hand hygiene before donning new set of gloves. Review of the facility policy and procedure titled Enhanced Barrier Precautions with the last review date of 1/23/2024 showed it read, Policy: Enhanced barrier precautions (EBP) is used to reduce the spread of Multidrug-resistant organisms (MDROs) among residents by utilizing gloves and gowns for high contact resident care activities. Definitions . High contact care activity- provide opportunities for transfer of MDRO to staff hands and clothing. High contact care activities include: dressing, bathing/showering, transferring, providing hygiene, such as brushing teeth, combing hair and shaving, changing linens, incontinent care, toileting, device care or use, such as central line, urinary catheter, feeding tube, tracheostomy or ventilator, wound care. Enhanced Barrier Precautions (EBP): the infection control process that reduces the spread of MDROs by using gloves and gowns for high contact care activities . Procedure: 1. Identify residents who are appropriate for EBP including . b. Resident who have a wound and/or indwelling medical devices. Review of the facility policy and procedure titled Dressing Change with the last review date of 1/23/2024 showed it read, Policy: A clean dressing will applied [Sic] by a nurse to a wound as ordered to promote healing. Sterile dressing will be used only if specifically ordered. Procedure . Perform hand hygiene, Apply gloves, Remove and dispose of soiled dressing, Remove gloves, Perform hand hygiene, Apply gloves, Evaluate wound for type, color, amount of drainage, Cleanse wound as ordered, dispose of gauze, Remove gloves and perform hand hygiene. Review of the facility's Skills Competency Assessment: Clean Dressing Change with the last review date of 1/23/2024 showed it read, The employee demonstrates skills and competence in the following . 10. Place supplies on prepped work surface and position wastebasket/bag in accessible area for dressing disposal per universal precautions. 11. Perform hand hygiene (soap and water or hand sanitizer) and apply gloves. 12. Open dressing packaging, Write date, time and nurse initials on cover of dressing or pre-cut tape. wipe scissors before and after use with alcohol pad. 13. Remove gloves. perform hand hygiene (soap and water or hand sanitizer). 14. Apply glove. Provide privacy and position resident comfortably and appropriately. Monitor pain level prior to beginning and during dressing change. 15. Place a clean barrier under area to be dressed. 16. Remove soiled dressing and dispose of as per policy. 17. Remove gloves. Performed hand hygiene. 18. Apply gloves. Assess wound for type, color, amount of drainage. Obtain wound culture if indicated. 19. Cleanse wound as ordered . 21. Remove gloves. Perform hand hygiene. 22. Don gloves and applies [Sic] treatment as ordered. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy and procedure titled Hand Hygiene with the last review date of 1/23/2024 showed it read, Overview: The CDC [Centers for Disease Control and Prevention] defines hand hygiene as cleaning your hands by using either handwashing (washing with soap and water), antiseptic hand wash, or antiseptic hand rubs (i.e. alcohol-based sanitizer including foam or gel) . Process: Hand hygiene should be performed . After contact with blood, body fluids, or excretions, mucous membranes, non-intact skin, or wounds dressings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have policies on smoking. 46523 Based on observation, interview, and record review, the facility failed to follow safe smoking practices for 4 of 5 residents reviewed for accidents, Resident #3, #15, #35, and #61. Findings include: 1. During an observation on 8/12/2024 at 8:49 AM, there was a pink device with mouth piece on top of drawer in Resident #3 room. Review of Resident #3's Smoking Evaluation dated 8/12/2024 showed it read, Summary of Evaluation: Resident is determined to be 0. Safe Smoker. Review of Resident #3's care plan initiated on 5/3/2024 showed it read, Focus: The resident smokes a vape . Interventions . Notify charge nurse immediately if it is suspected resident has violated facility smoking policy. During an observation on 8/13/2024 at 2:55 PM, with Staff G, Licensed Practical Nurse (LPN) Unit Manager, the smoking box located in the nursing station did not contain any vaping devices. During an interview on 8/13/2024 at 2:55 PM, Staff G, LPN Unit Manager, stated, It is not smoking time. The vapes should be in the box stored away. I do not see any vapes in the box, not sure where they could be. The staff scheduled for supervising the smoking break is responsible for collecting the vapes when it is the end of the smoking break. 2. During an observation on 8/13/2024 at 3:13 PM, Resident #35 was sitting up in his bed with a black vaping device on top of the resident's bedside table in front of him. During an interview on 8/13/2024 at 3:13 PM, Resident #35 stated, We were told we could have our vapes with us. I do not go outside to use it. I vape in my room. You cannot smell it. The staff and doctors have seen me and have not said anything to me. Review of Resident #35's Smoking Evaluation dated 8/12/2024 showed it read, Summary of Evaluation: Resident is determined to be 0. Safe Smoker. Review of Resident #35's care plan initiated on 5/3/2024 showed it read, Focus: [Resident #35's name] smokes a vape . Interventions . Notify charge nurse immediately if it is suspected resident has violated facility smoking policy. 3. During an observation on 8/13/2024 at 3:21 PM, Resident #15 had a vaping device on top of his bed. Resident #15 handed the vape to the Director of Nursing (DON). During an interview on 8/13/2024 at 3:21 PM, Resident #15 stated, I always have my vape with me, but you can take it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105461	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Brentwood	2333 N Brentwood Cir Lecanto, FL 34461

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #15's Smoking Evaluation dated 8/12/2024 showed it read, Summary of Evaluation: Resident is determined to be 0. Safe Smoker. Review of Resident #15's care plan initiated on 5/3/2024 showed it read, Focus: The resident smokes a vape . Interventions . Notify charge nurse immediately if it is suspected resident has violated facility smoking policy. 4. During an observation on 8/13/2024 at 3:23 PM, Resident #61 was sitting up in his bed. When the DON requested the vape device, the resident refused. After the DON explained the policy, Resident #61 top out vape device from inside a bed pan on top of his bedside table and gave it to the DON. During an interview on 8/13/2024 at 3:23 PM, Resident #61 stated, It is my right to have my vape. I am not a prisoner. I have never signed a policy stating I am not able to have the vape with me. Review of Resident #61's Smoking Evaluation dated 8/12/2024 showed it read, Summary of Evaluation: Resident is determined to be 0. Safe Smoker. Review of Resident #61's care plan initiated on 5/3/2024 showed it read, Focus: The resident smokes a vape . Interventions . Notify charge nurse immediately if it is suspected resident has violated facility smoking policy. During an interview on 8/13/2024 at 3:30 PM, with the DON stated, I have been here in the facility for two months and we know this is a problem and we are working towards addressing the compliance of turning in the vapes at the end of the smoking times. [Resident #3's name] did have it in her room and we removed the vaping device form her room. Review of the facility policy and procedure titled Smoking-Supervised with the last review date of 1/23/2024 showed it read, Policy: The center will provide a safe, designated smoking area for residents. For the safety of all residents the designated smoking area will be monitored by a staff member during authorized smoking times. Smoking is only allowed in designated areas and during designated times . Procedure . 8. Electronic cigarettes are permitted, but only in facility designated smoking areas. a. The same rules that apply to regular tobaccos cigarettes also apply to electronic smoking materials. b. Electronic cigarettes and materials, including the liquids, will be retained and stored by nursing staff.