STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Healthcare Center	333 W Mishawaka Rd Elkhart, IN 46517

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 46756 Based on observation, interview, and record review the facility failed to ensure freedom from verbal abuse for 2 of 8 residents reviewed (Resident F and Resident G). Findings include: 1) A complaint filed with the Indiana Department of Health, dated 1/13/25 indicated Resident G filed a grievance alleging Licensed Practical Nurse (LPN) 5 had been rude and used foul language to Resident F during a medication pass. The report indicated Resident F asked LPN 5 to bring her some water to take her medication when the nurse entered the room with her pills. LPN 5 grabbed the pills from her bedside table and indicated Resident F should let her know when she wanted to take her pills. She indicated Resident F could not have a breathing treatment because her heart rate was too high. Resident F told LPN 5 her heart rate might not be so high if LPN 5 was not being a b****. The complainant indicated LPN 5 closed the door, and then reopened it, put her head in the doorway, called Resident F a b**** and closed the door. The complainant indicated the Administrator rewrote the grievance, changing what had been originally stated. Resident F's record was reviewed on 1/29/25 at 1:20 PM. Diagnoses included chronic obstructive pulmonary disease, and chronic respiratory failure with hypoxia. Resident F's current Minimum Data Set (MDS) indicated Resident F's Basic interview for Mental Status (BIMS) score was 15 (cognitively intact). (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview, on 1/29/25 at 1:27 PM, Resident F indicated a few weeks ago, she had requested a breathing treatment from LPN 5. LPN 5 obtained a heart rate by a pulse oximeter device and informed Resident F her heart rate was too high to receive a breathing treatment. Resident F indicated LPN 5 was rude during the interaction and it upset her. Resident 5 indicated the next day, LPN 5 came to give her medicine, did not bring fresh water and indicated Resident F should use the water that was at her bedside. Resident F indicated to LPN 5 the water had been sitting since the day before and she wanted some fresh water to take her medicine. LPN 5 indicated Resident F was being difficult with her because she asked for fresh water. The resident indicated LPN 5 took her medicine cup away from her, indicated she would come back when she was ready to take her medicine and did not provide her with any fresh water. Resident F indicated she requested a breathing treatment and LPN 5 told her she could not have it due to her heart rate being too high. She indicated LPN 5's tone and body language were rude, causing her to become angry. Resident F indicated she told LPN 5 her heart rate would not be high if the nurse weren't being a b****. Resident F indicated LPN 5 stormed out of the room and closed the door. A few seconds later LPN 5 opened the door, peeked her head in and indicated Resident F was a b****. Resident F indicated she did not see LPN 5 for a long time after the occurrence. She indicated LPN 5 was her nurse last night for the first time in a while. She indicated LPN 5 poked her hard with her finger in the left shoulder to awaken her when it was time to take her medicine. She indicated the poking was painful due to LPN 5's long fingernails. She indicated LPN 5 was rude and standoffish during the encounter. She indicated she felt intimidated by LPN 5 and was afraid she would not receive her medicine when LPN 5 was working. Progress notes dated 12/30/24 at 7:59 AM indicated social services visited Resident F and assessed her for psychosocial distress. Progress notes dated 1/1/25 at 8:01 AM indicated social services visited Resident F and assessed for psychosocial distress. Progress notes dated 1/2/25 at 11:24 AM indicated social services visited Resident F and assessed for psychosocial distress. During a confidential interview on 1/28/25 at 6:28 PM, Employee 2 indicated they were aware of an occurrence of Nurse 5 calling Resident F a b****. They indicated Resident F reported LPN 5 to management. The staff were not interviewed or aware of any interviews being done to investigate the matter. Employee 2 indicated calling a resident a b**** was a form of verbal abuse. During a confidential interview on 1/29/25 at 1:05 PM, Employee 6 indicated Resident F came to them a few weeks ago and asked to file a grievance. Resident F told them a nurse passing her meds became rude after Resident F had asked for water with her pills and a breathing treatment. Resident F said she was denied the breathing treatment because her heart rate was too high. Resident F then told the nurse it might not be so high if she was not being a b****. Employee 6 indicated LPN 5 left the room closing the door, then reopened the door, told Resident F she was a b**** and closed the door again. Employee 6 indicated they presented the grievance to the Administrator immediately. Employee 6 indicated they normally were assigned to interview residents in the area and check for any psychosocial effects when such allegations were made. Employee 6 indicated they were not assigned to do any additional interviews in this instance. She indicated calling a resident a b**** was an example of verbal abuse. She indicated psychosocial assessment visits are generally provided for three days or more if indicated after an occurrence of abuse. (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a confidential interview on 1/29/25 at 1:24 PM, Employee 7 indicated they witnessed a grievance being filled out with Resident F. They indicated the grievance stated LPN 5 had cursed at Resident F. 2) During an interview on 1/29/24 at 1:31 PM, Resident G indicated she had witnessed LPN 5 being rude to Resident F on a few occasions. She indicated she recalled an occasion where Resident F and LPN 5 had an argument over medicine. She indicated she heard Resident F call LPN 5 a b****, then LPN 5 returned to the room and called Resident F a b****. She indicated residents used that word on occasion, but staff should not be addressing residents like that. She indicated the incident made her uncomfortable. A record review conducted on 1/29/25 at 1:22 PM indicated Resident G had diagnoses including heart failure and hypertension. Resident G's current MDS indicated her BIMS score was 15 (cognitively intact). A document titled Concern Form, dated 1/2/25, provided by the Social Services Director on 1/29/25 at 1:16 PM indicated Resident F reported LPN 5 was rude to her and she, the resident, cursed at the nurse. The response section of the form indicated the Administrator spoke at length with the nurse regarding the incident. The form indicated the nurse was counseled on her attitude and approach with residents and peers. The form indicated the nurse denied cursing and no one reported hearing the nurse curse. The form was signed by the Administrator and dated 12/31/25. In an interview, on 1/29/25 at 1:36 PM, the Administrator indicated she had interviewed Resident F about her interaction with LPN 5, the resident indicated LPN 5 seemed annoyed and used a rude tone with her, but did not mention the nurse had called her a b****. The Administrator indicated she notified her supervisors and followed corporate guidance. She indicated she did not report the abuse allegation to the department of health because she did not view the interaction as possible abuse. She indicated she did not conduct an investigation or interview staff or other residents about the allegations. She indicated she had interviewed LPN 5 and the nurse denied using foul language. The Administrator indicated she had no further statements or interviews of residents or employees available for review. The Administrator did not provide an explanation of the need to question the nurse about cursing if it was not in the allegation, or the signature date on the concern form occurring before the date of the concern. A current policy titled Abuse and Neglect and Misappropriation Property, undated, provided by the Administrator on 1/28/25 at 1:58 PM indicated use of foul language directed at a resident constituted verbal abuse. This citation is related to complaint IN00451234. 3.1-27(a)(b)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 46756 Based on observation, interview, and record review the facility failed to ensure an occurrence of verbal abuse was reported to the Department of Health for 1 of 8 residents reviewed (Resident F). Findings include: A complaint filed with the Indiana Department of Health, dated 1/13/25, indicated Resident G filed a grievance alleging Licensed Practical Nurse (LPN) 5 had been rude and used foul language to Resident F during a medication pass. The report indicated Resident F asked LPN 5 to bring her some water to take her medication when she entered the room with her pills. LPN 5 grabbed the pills from the resident's bedside table and indicated Resident F should let her know when she wanted to take her pills. The nurse indicated Resident F could not have a breathing treatment because her heart rate was too high. Resident F told LPN 5 her heart rate might not be so high if LPN 5 was not being a b****. The complainant indicated LPN 5 closed the door, then reopened it, put her head in the doorway, called Resident F a b**** and closed the door. The complainant indicated the Administrator rewrote the grievance, changing what had been originally stated. Resident F's record was reviewed on 1/29/25 at 1:20 PM. Diagnoses included chronic obstructive pulmonary disease, and chronic respiratory failure with hypoxia. Resident F's current Minimum Data Set (MDS) indicated Resident F's Basic interview for Mental Status (BIMS) score was 15 (cognitively intact). Survey report system documents submitted by the facility for December 2024 and January 2025, provided by the Administrator on 1/28/25 at 1:40 PM, did not include a report of an allegation of verbal abuse against Resident F had been reported. During a confidential interview, on 1/28/25 at 6:28 PM, Employee 2 indicated they were aware of an occurrence of Nurse 5 calling Resident F a b****. They indicated Resident F reported LPN 5 to management. Employee 2 indicated they were not interviewed or aware of any interviews being done to investigate the matter. They indicated calling a resident a b**** is a form of verbal abuse. During a confidential interview, on 1/29/25 at 1:05 PM, Employee 6 indicated Resident F came to them and asked to file a grievance. They indicated Resident F told them a nurse passing her meds became rude after Resident F had asked for water with her pills and a breathing treatment. She indicated Resident F said she was denied the breathing treatment because her heart rate was too high. Resident F then told the nurse it might not be so high if she was not being a b****. She indicated LPN 5 left the room closing the door, then reopened the door, told Resident F she was a b**** and closed the door again. Employee 6 indicated they presented the grievance to the Administrator immediately. Employee 6 indicated they normally were assigned to interview residents in the area and check for any psychosocial effects when such allegations were made. They indicated they were not assigned to do any additional interviews in this instance. They indicated calling a resident a b**** was an example of verbal abuse. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a confidential interview, on 1/29/25 at 1:24 PM, Employee 7 indicated they witnessed a grievance being filled out with Resident F. She indicated the grievance stated LPN 5 had cursed at Resident F. In an interview, on 1/29/25 at 1:27 PM, Resident F indicated she had requested a breathing treatment from LPN 5. LPN 5 obtained a heart rate by a pulse oximeter device and informed Resident F her heart rate was too high to receive a breathing treatment. Resident F indicated LPN 5 was rude during the interaction and it upset her. Resident 5 indicated the next day, LPN 5 came to give her medicine, did not bring fresh water and indicated the should use the water that was at Resident F's bedside. Resident F indicated to LPN 5 the water had been sitting since the day before and she wanted some fresh water to take her medicine. LPN 5 indicated Resident F was being difficult with her because she asked for fresh water. The resident indicated LPN 5 took her medicine cup away from her and indicated she would come back when she was ready to take her medicine and did not provide her with any fresh water. Resident F indicated she requested a breathing treatment and LPN 5 told her she could not have it due to her heart rate being too high. She indicated LPN 5's tone and body language were rude, causing her to become angry. Resident F indicated she told LPN 5 her heart rate would not be high if she weren't being a b****. Resident F indicated LPN 5 stormed out of the room and closed the door. A few seconds later, LPN 5 opened the door, peeked her head in and indicated Resident F was a b****. Resident F indicated she did not see LPN 5 for a long time after the occurrence. She indicated LPN 5 was her nurse last night for the first time in a while. She indicated LPN 5 poked her hard with her finger in the left shoulder to awaken her when it was time to take her medicine. She indicated the poking was painful due to LPN 5's long fingernails. She indicated LPN 5 was rude and standoffish during the encounter. She indicated she felt intimidated by LPN 5 and was afraid she would not receive her medicine when LPN 5 was working. A document titled Concern Form, dated 1/2/25, provided by the Social Services Director on 1/29/25 at 1:16 PM indicated Resident F reported a nurse was rude to her and she, the resident cursed at the nurse. The response section of the form indicated the Administrator spoke at length with the nurse regarding the incident. The form indicated the nurse was counseled on her attitude and approach with residents and peers. The form indicated the nurse denied cursing and no one reported hearing the nurse curse. The form was signed by the Administrator and dated 12/31/24. In an interview on 1/29/25 at 1:36 PM, the Administrator indicated she had interviewed Resident F about her interaction with LPN 5, she indicated LPN 5 had seemed annoyed and used a rude tone with her, but did not mention the nurse had called her a b****. She indicated she notified her supervisors and followed corporate guidance. She indicated she did not report the abuse allegation to the department of health because she did not view the interaction as possible abuse. She indicated she did not conduct an investigation or interview staff or other residents about the allegations. She indicated she had interviewed LPN 5, and she denied using foul language. The Administrator indicated she had no further statements or interviews of residents or employees available for review. The Administrator did not provide an explanation of the need to question the nurse about cursing if it was not in the allegation or the signature date occurring before the date of the concern. The Administrator indicated upon receiving an allegation of abuse, the employee should be suspended, the Department of Health should be notified, and the Administrator should begin an investigation. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current policy titled Abuse, Neglect and Misappropriation of Property, undated, provided by the Administrator on 1/28/25 at 1:58 PM indicated use of foul language directed at a resident constituted verbal abuse. The policy indicated required notification of agencies, the physician and resident representative should be completed in a timely manner. This citation is related to complaint IN00451234. 3.1-28(c)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 46756 Based on observation, interview, and record review the facility failed to ensure an allegation of verbal abuse was investigated for 2 of 8 residents reviewed (Resident F, Resident G). Findings include: 1) A complaint filed with the Indiana Department of Health indicated Resident G filed a grievance alleging Licensed Practical Nurse (LPN) 5 had been rude and used foul language to Resident F during a medication pass. Resident F asked LPN 5 to bring her some water to take her medication when she entered the room with her pills. LPN 5 grabbed the pills from her bedside table and indicated Resident F should let her know when she wanted to take her pills. She indicated Resident F could not have a breathing treatment because her heart rate was too high. Resident F told LPN 5 her heart rate might not be so high if LPN 5 was not being a b****. The complainant indicated LPN 5 closed the door, then reopened it, put her head in the doorway, called Resident F a b**** and closed the door. The complainant indicated the Administrator rewrote the grievance, changing what had been originally stated. Resident F's record was reviewed on 1/29/25 at 1:20 PM. Diagnoses included chronic obstructive pulmonary disease, and chronic respiratory failure with hypoxia. Resident F's current Minimum Data Set (MDS) indicated Resident F's Basic interview for Mental Status (BIMS) score was 15 (cognitively intact). During a confidential interview, on 1/28/25 at 6:28 PM, Employee 2 indicated they were aware of an occurrence of Nurse 5 calling Resident F a b****. The employee indicated Resident F reported LPN 5 to management, and they were not interviewed or aware of any interviews being done to investigate the matter. They indicated calling a resident a b**** is a form of verbal abuse. During a confidential interview, on 1/29/25 at 1:05 PM, Employee 6 indicated Resident F came to them and asked to file a grievance. They indicated Resident F told them a nurse passing her meds became rude after Resident F had asked for water with her pills and a breathing treatment. She indicated Resident F said she was denied the breathing treatment because her heart rate was too high. Resident F then told the nurse it might not be so high if she was not being a b****. She indicated LPN 5 left the room closing the door, then reopened the door, told Resident F she was a b**** and closed the door again. Employee 6 indicated they presented the grievance to the Administrator immediately. Employee 6 indicated they normally were assigned to interview residents in the area and check for any psychosocial effects when such allegations were made. They indicated they were not assigned to do any additional interviews in this instance. They indicated calling a resident a b**** was an example of verbal abuse. In a confidential interview, on 1/29/25 at 1:24 PM, Employee 7 indicated they witnessed a grievance being filled out with Resident F. She indicated the grievance stated LPN 5 had cursed at Resident F. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview, on 1/29/25 at 1:27 PM, Resident F indicated she had requested a breathing treatment from LPN 5. LPN 5 obtained a heart rate by a pulse oximeter device and informed Resident F her heart rate was too high to receive a breathing treatment. Resident F indicated LPN 5 was rude during the interaction and it upset her. Resident 5 indicated the next day, LPN 5 came to give her medicine and did not bring fresh water and indicated she should use the water that was at Resident F's bedside. Resident F indicated to LPN 5 the water had been sitting since the day before and she wanted some fresh water to take her medicine. LPN 5 indicated Resident F was being difficult with her because she asked for fresh water. She indicated LPN 5 took her medicine cup away from her, indicated she would come back when she was ready to take her medicine and did not provide her with any fresh water. Resident F indicated she requested a breathing treatment and LPN 5 told her she could not have it due to her heart rate being too high. She indicated LPN 5's tone and body language were rude, causing her to become angry. Resident F indicated she told LPN 5 her heart rate would not be high if she weren't being a b****. Resident F indicated LPN 5 stormed out of the room and closed the door. A few seconds later LPN 5 opened the door, peeked her head in and indicated Resident F was a b****. Resident F indicated she did not see LPN 5 for a long time after the occurrence. She indicated LPN 5 was her nurse last night for the first time in a while. She indicated LPN 5 poked her hard with her finger in the left shoulder to awaken her when it was time to take her medicine. She indicated the poking was painful due to LPN 5's long fingernails. She indicated LPN 5 was rude and standoffish during the encounter She indicated she felt intimidated by LPN 5 and was afraid she would not receive her medicine when LPN 5 was working. 2) During an interview, on 1/29/24 at 1:31 PM, Resident G indicated she had witnessed LPN 5 being rude to Resident F on a few occasions. She indicated she recalled an occasion where Resident F and LPN 5 had an argument over medicine She indicated she heard Resident F call LPN 5 a b****, and LPN 5 returned to the room indicating Resident F was a b****. She indicated residents used that word on occasion, but staff should not be addressing residents like that. She indicated the incident made her uncomfortable. A record review conducted on 1/29/25 at 1:22 PM indicated Resident G had diagnoses including heart failure and hypertension. Resident G's current MDS indicated her BIMS score was 15 (cognitively intact). A document titled Concern Form, dated 1/2/25, provided by the Social Services Director on 1/29/25 at 1:16 PM indicated Resident F reported a nurse was rude to her and she cursed at the nurse. The response section of the form indicated the Administrator spoke at length with the nurse regarding the incident. The form indicated the nurse was counseled on her attitude and approach with residents and peers. The form indicated the nurse denied cursing and no one reported hearing the nurse curse. The form was signed by the Administrator and dated 12/31/24. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview, on 1/29/25 at 1:36 PM, the Administrator indicated she had interviewed Resident F. about her interaction with LPN 5. She indicated LPN 5 had seemed annoyed and used a rude tone with her, but did not mention the nurse had called her a b****. She indicated she notified her supervisors and followed corporate guidance. She indicated she did not report the abuse allegation to the department of health because she did not view the interaction as possible abuse She indicated she did not conduct an investigation or interview staff or other residents about the allegations. She indicated she had interviewed LPN 5 and she denied using foul language. The Administrator indicated she had no further statements or interviews of residents or employees available for review The Administrator did not provide an explanation of the need to question the nurse about cursing if it was not in the allegation or the signature date occurring before the date of the concern. A current policy titled Abuse, Neglect and Misappropriation of Property, undated, provided by the Administrator on 1/28/25 at 1:58 PM indicated use of foul language directed at a resident constituted verbal abuse. The policy indicated each occurrence of abuse should be investigated timely. The policy indicated the Administrator was responsible for directing the investigation. This citation is related to complaint IN00451234. 3.1-28(d)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46756 Based on observation, interview, and record review the facility failed to ensure assessment, education and care planning were accurately recorded pertaining to smoking for 1 of 4 residents reviewed (Resident D). Findings include: A complaint addendum filed with the Department of Health, dated 1/16/25, indicated some residents had been smoking in their rooms the previous night. The complainant indicated the Administrator had told the nursing staff on duty not to document the indoor smoking in the residents' charts. The complainant also alleged the Administrator instructed the department heads and corporate staff present in the morning meeting the following day not to chart anything about the indoor smoking. During an observation, on 1/29/24 at 1:45 PM, Resident D was observed in the smoking area with a lit cigarette smoking An unidentified staff member was supervising several residents in the smoking area at the time. During an interview ,on 1/29/25 at 1:46 PM, Resident D indicated he smoked at the designated times posted inside the door with a staff member present.He indicated some residents smoked independently and some needed to be supervised. He indicated he did not know why he had to be supervised. Resident D's record was reviewed on 1/29/24 at 11:22 AM. Diagnoses included chronic obstructive pulmonary disease and shortness of breath. Resident D's current quarterly Minimum Data Set (MDS) indicated their Basic Interview for Mental Status (BIMS) score was 15 (cognitively intact). Resident D's current care plan titled .uses nicotine products .Resident is a supervised smoker .indicated the resident had a problem of using cigarettes, with a goal date of 4/22/25. Interventions included educating the resident to use the smoking area to smoke, and the resident is an independent smoker. A smoking assessment dated [DATE] indicated Resident D used cigarettes and was independent with smoking. A smoking assessment dated [DATE] indicated Resident D used cigarettes and required supervision to smoke cigarettes. No changes in diagnoses, cognition, vision, dexterity, frequency or safety were indicated on the form to validate the change in status. No progress notes between 1/15/24 and 1/21/24 pertaining to smoking were available for review. In an interview, on 1/28/25 at 10:12 AM, the Director of Nursing indicated Resident D, and another resident were caught smoking in their rooms on a very cold day because they were angry about not being able to go outside and smoke. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview, on 1/28/25 at 11:13 AM, the Administrator indicated she was aware of a different resident having an occurrence of indoor smoking but was not aware of any others. In a confidential interview, on 1/29/25 at 1:05 PM Employee 6 indicated they were aware of a few residents who reportedly smoked in their rooms on a very cold day when they were not allowed to go outside due to the low temperatures. Employee 6 indicated a new smoking assessment was done to indicate Resident D now required supervision due to smoking indoors. They indicated the Administrator announced in the morning meeting that staff were not allowed to document the occurrences of indoor smoking. They indicated upon a violation of the smoking policy, staff should stop the resident from smoking in an unsafe area, educate them on the policy and safety standards, remove the smoking materials from their possession, perform a new smoking assessment and update the care plan. All the events should be documented and reported to the physician and representative. A current policy titled Resident/Patient smoking dated 3/25/16 provided by the Administrator on 1/28/25 at 1:58 PM indicated smoking supervision changes were made by the interdisciplinary team recommendations. The policy indicated staff should document the reason for the need to change, update the care plan and document resident and family notification. The policy also indicated smoking should only occur in designated areas. This citation is related to complaint IN00451234. 3.1-45 (a)(2)