STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455565	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palestine Healthcare Center	1816 Tile Factory Rd Palestine, TX 75801

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents have a right to personal privacy for 1 of 12 (Resident #6) residents observed for care. The ADON failed to provide Resident #6 with full privacy while providing gastric tube care on 08/12/25. This failure could place residents at risk of not being treated with dignity and respect. Findings:Record review of a facility face sheet dated 08/12/25indicated Resident #6 was a [AGE] year-old male that was admitted to the facility on [DATE]. He was re-admitted on [DATE] with diagnosis of tracheostomy (airway surgically created in the trachea), gastrostomy (tube placed surgically into the stomach for feeding), cerebral ischemia (decreased circulation in the brain), muscle wasting and dysphagia (inability to swallow). Record review of a comprehensive care plan revised 7/20/25 indicated Resident #6 required a gastrostomy tube (a tube placed in the stomach) for feeding and medication administration.Record review of a Quarterly MDS assessment dated [DATE] indicated Resident #6 had a BIMS score of 14 which indicated intact cognition and was dependent on staff for gastrostomy tube care and positioning. During an observation on 08/12/25 at 09:00 AM Resident #6 was provided gastrostomy care by the ADON. The ADON did not pull the privacy curtain between the room and door or close the door to the hallway. Resident #6 was visible from the hallway while visitors, staff and other residents passed by the open doorway. At 09:15 AM CNA B knocked on Resident #6's door and walked in room while resident was receiving care and drew the privacy curtain around resident #6 and closed the door. During an interview on 08/12/25 at 09:30 AM the ADON said she had been trained on resident privacy and dignity. She said the privacy curtain should have been pulled to keep Resident #6 from being exposed to the hallway. She said the resident could be upset being exposed and privacy not maintained. During an interview on 08/12/25 at 09:45 AM CNA B said she had been trained on resident privacy and dignity. She said the privacy curtain should have been pulled to keep Resident #6 from being exposed to the hallway. She said the resident could be exposed and embarrassed being exposed and privacy not maintained. During an interview on 08/12/25 at 10:59 AM Resident #6 nodded his head yes, when asked if it bothered him when the staff don't pull his privacy curtain, and he felt exposed and embarrassed. During an interview on 08/13/25 at 10:53 AM the DON said she was responsible for oversight of all nursing staff and education on resident rights. She said all staff should pull the privacy curtain during care. She said by not doing so it could make a resident feel exposed, embarrassed, or rushed. She said she expected all staff to maintain resident rights and dignity.During an interview on 08/13/25 at 11:00 AM the Administrator said all employees were responsible for following resident rights and ensuring resident privacy and dignity were maintained. The Administrator said she expected all staff to always respect resident privacy and dignity. Record review of a facility policy dated 2/2021 titled Dignity indicated, .Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem .

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

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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. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to provide a safe, clean, comfortable and homelike environment 1 of 4 halls (room [ROOM NUMBER]) reviewed for environment.The facility failed to repair the window in Resident #2's room [ROOM NUMBER] that had a broken frame that had detached from the wall on 8/12/2025.This failure could place the residents at risk of living in an unsafe, unsanitary, and uncomfortable environment. Findings included:Record review of a Resident Face Sheet for Resident #2 dated 8/12/2025 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of schizoaffective disorder (a mental illness that can cause hallucinations and delusions), atherosclerotic heart disease (plaque buildup that causes narrowing and limited blood flow in the blood vessels), and polyosteoarthritis (joint stiffness and pain in multiple areas).Record review of a Quarterly MDS assessment dated [DATE] indicated she had moderate impairment in thinking with a BIMS score of 11. She required substantial/maximal assistance with personal hygiene.Record review of a care plan for Resident #2 dated 12/31/2024 indicated she had a self-care deficit related to schizoaffective disorder with intervention for two staff to assist with bed mobility.Record review of maintenance records dated 8/12/2025 indicated there was not a request for the repair of the window in room [ROOM NUMBER].During an observation on 8/12/2025 at 10:18 AM, CNA B was in the room to provide care to Resident #2. Resident #2's bed was positioned by the window. The window frame at the bottom of the window was detached from the wall, with one screw and one nail exposed with the top of them showing that were about one-half inch out of the wall.During an observation and interview on 8/12/2025 at 10:22 AM, CNA B was in room [ROOM NUMBER]. CNA B said she did not notice the window in the room when she provided care to Resident #2 because her bed was right against the wall. She said the window frame was detached from the wall. She said if they noticed any issues they were supposed to report it to the Maintenance Supervisor by scanning a QR code that was at the nurses'desk. She said residents could be at risk for injury if the window was not repaired.During an observation and interview on 8/12/2025 at 3:03 PM, CNA C observed the window frame in Resident #2's room and said she was not aware that anything was wrong with her window. She said the window frame was detached and said she would report it to Maintenance. Resident #2 was in bed awake and said it had been repaired a while ago but was not sure how long this time it had been broken. CNA C said there was a risk for injury, or it could allow bugs into the facility if the window frame was broken.During an observation and interview on 8/12/2025 at 3:25 PM, the Maintenance Supervisor was in room [ROOM NUMBER] working on repairing the window frame. He said he had been employed at the facility for 6 weeks. He said staff usually put in work orders for him that he would check every hour daily. He said he was not aware of the window in that room until that day. He said residents could be at risk for getting cuts, scrapes, or bruises if the window frame was not repairedDuring an interview on 8/13/2025 at 2:38 PM, the SW said the department heads conducted angel rounds in the facility daily where the staff were assigned rooms to check for environment issues and any other deficiencies. He said he was assigned the hall where Resident #2 resided. He said he checked her room daily but did not check the window because the blinds were always closed and did not think there were any issues with the window. He said if staff noticed anything in the rooms that needed repair, they were to report it to the Administrator during the morning meetings. He said staff could also scan the QR codes around the facility that would notify the Maintenance Supervisor of issues that needed repair. He said there was a risk of safety concerns if repairs were not reported.During an interview on 8/13/2025 at 2:53 PM, the Administrator said the department heads in the facility were assigned rooms that they were to check daily. She said they were to check and report any environment issues. She said throughout the facility, any staff could scan QR codes to report issues that needed to be repaired directly to the Maintenance Supervisor. She said she was not made aware of Resident #2's window until yesterday 8/12/2025. She said she would in-service the staff in the facility on reporting issues to maintenance and expected the staff to communicate more. She said environment issues that were found during the angel rounds were discussed in the morning meetings daily and the window in room [ROOM NUMBER] was not discussed. Record review of a facility policy titled Homelike Environment revised February 2021 indicated, .Residents are provided with a safe, clean, comfortable and homelike environment. 2. The facility staff and management maximized, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. The characteristics include: a. clean, sanitary, and orderly environment

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were fed by enteral means received the appropriate treatment and services to prevent complications for 1 of 1 resident reviewed for tube feeding management (Resident #6).The facility failed to follow their policy for maintaining Resident #6's positioning while administering medications via gastrostomy tube on 8/12/2025.The facility failed to follow their policy for labeling gastrostomy tube feeding for Resident #6 on 08/12/2025.These failures placed the resident at risk for aspiration of water/feedings and reduced therapeutic effects of gastrostomy feedings by not following current clinical standards of care.Findings included: Record review of a facility face sheet dated 08/12/25indicated Resident #6 was a [AGE] year-old male that was admitted to the facility on [DATE]. He was re-admitted on [DATE] with diagnoses of tracheostomy (airway surgically created in the trachea), gastrostomy (tube placed surgically into the stomach for feeding), cerebral ischemia (decreased circulation in the brain), muscle wasting and dysphagia (inability to swallow). Record review of a Quarterly MDS assessment dated [DATE] indicated Resident #6 had a BIMS score of 14 which indicated intact cognition and was dependent on staff for gastrostomy tube care and positioning. Record review of a comprehensive care plan revised 7/20/25 indicated Resident #6 required a gastrostomy tube (a tube placed in the stomach) for feeding and medication administration.Record review of a comprehensive care plan revised 06/20/2025 indicated: Resident requires feeding tube related to pharyngeal dysphagia. Peg- tube placed on 10/4/24. He is at risk for aspiration r/t noncompliance with positioning in bed. He will purposely scoot down in bed to a lying position. Resident will not exhibit signs of complications from feeding tube or enteral feeding solution through next 90 days.Record review of consolidated physician orders dated 08/12/2025 indicated: Enteral Administration Set & Bag - Change every 24 hours.Special Instructions: Residents name, Date, Time, and initials of nurse on feeding, Flush bag and tubing Once A Day-Enteral Feeding (Aspiration Precaution) Elevate HOB 30-45 degrees Every Shift.During an observation and interview on 08/12/2025 at 08:45 AM Resident #6 was lying supine (on back with face up) in bed with head of bed at 10 - 15 degrees elevation. Resident #6's gastrostomy tube (tube in stomach for feeding) feeding was infusing per pump with the label blank with no date, time or initials when hung. The ADON said the feeding should be labeled with date, time and initial when hung. She said there was a risk of the feeding not being changed as needed or the infusion of the feeding not administered as ordered.During an observation on 08/12/2025 at 09:00 AM Resident #6 was lying supine in bed with head of bed at 10- 15 degrees elevation. The ADON administered g-tube flushes before administration of meds and after each medication as ordered per medical doctor. Resident #6 continued to be lying supine in bed with head of bed at 10- 15 degrees elevation. Resident #6 began coughing and the ADON raised the head of bed to over 45 degrees per standard of care.During an observation and interview on 08/12/2025 at 09:10 Resident #6 nodded he was alright, smiled and coughing subsided.During an observation on 8/12/2025 at 12:00 PM Resident #6 was in the dining room participating in music activities, he was laughing and communicating with staff. Resident #6 had no negative effects observed from flushes.During an interview on 8/12/2025 at 09:30 AM the ADON said she should have raised the head of bed before beginning the flushes and medication administration. She said by not maintaining the resident in position as ordered he was at risk for aspiration of his water flushes and feedings. The ADON said that the feedings should always be labeled as required by facility policy.During an interview on 8/13/2025 at 08:30 AM the DON said she was responsible for ensuring the nursing staff followed standards of care and policies regarding g-tube feedings and positioning of residents during flushes to ensure the risk of aspiration was decreased. She said the ADON should have raised the head of bed before beginning the flushes and medication administration. She said by not maintaining the resident in fowlers position (head of head up at least 30-45 degrees) as ordered, placed the resident at risk for aspiration of his water flushes and feedings. The DON said she had already started an in-service to staff to ensure compliance with facility policies and standards of care concerning positioning of residents during gastrostomy tube feedings/flushes and labeling of gastrostomy tube feedings.During an interview on 08/13/2025 at 11:30 AM the Administrator said the DON was responsible for ensuring compliance to standards of care for feeding tubes. She said not labeling the feedings or keeping the head of bed raised could put the resident at risk for aspiration of water/feedings and reduced therapeutic effects by not following current clinical standards of care.Record review of a facility policy dated 07/01/2025 titled Flushing a Feeding Tube, Policy: It is the policy of this

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observations, interviews, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 Kitchen reviewed for food safety requirements and kitchen sanitation.The facility failed to ensure all food items stored in the refrigerator and freezer were dated and labeled.These failures could place residents at risk of foodborne illness and food contamination.Findings included:During an observation on 08/12/2025 at 8:28am-9:10am, the following undated and unlabeled items was identified by the dietary manager in the refrigerator and freezer:Freezer*1-bag of 12 premade waffles with no date or label.*3-gallon bags of precooked chicken with no date or label.*1-gallon bag of uncooked chicken no date or label.*1-gallon bag of breaded squash with no date or labelRefrigerator**9-pre-made fruit cups with no date or label.*2-5lb rolls of ground beef with no date or label.*1-6lb ham with no date or label.During an interview on 08/13/2025 at 9:55 AM with the DM he said food should be dated and labeled when it's opened and placed in a different container. He said when food comes into the facility it should be immediately dated and labeled and stored in the refrigerator, freezer or pantry. He said no dates and labels could cause the staff to cook something that is contaminated, out of date and cause illness to residents. During an interview on 08/13/2025 at 10:06 AM with Cook/Aide E she said dating and labeling should happen when storing leftovers and when food comes into to the kitchen it should be dated and labeled immediately. She said if food was not dated and labeled staff would not know the expiration date and may not be able to identity the food item. She said not dating and labeling food items could cause the staff to serve the wrong food and may cause sickness to the residents. During an interview on 08/13/2025 at 10:12 AM with Cook/Aide F, she said food should be dated and labeled upon deliver and prior to storing the food item. She said if staff opens food they should date and label the item with an open date and expiration date. She said if there was no date or label on all food products in the kitchen the staff could use expired foods and cause residents to get sick.During an interview on 08/13/2025 at 10:17 AM with the Dietitian she said food should be dated and labeled when it is received into the kitchen. She said staff should date and label food items when staff opens or removes food from its original container and when storing leftovers. She said when food was not dated and labeled correctly staff would not know the date it was delivered, the date it expires or the date it was opened. She said with no date or label to identify the item or expiration date the food could be bad and should not be served to the residents. She said if food was expired or spoiled it could cause food borne illness. During an interview on 08/13/2025 at 10:45 AM with the Administrator she said staff should be dating and labeling all foods when it was delivered in the kitchen. She said if there was left over food or if food was removed from its original container kitchen staff should apply a new label and date with the name of the item and the expiration date. She said if food was not dated and labeled the staff could serve expired foods or the wrong foods and could cause a severe allergic reaction to a resident or make residents ill. Record review of a facility policy titled Food Storage dated 10/01/2018, revised 06/01/2019 indicated, .It is the policy of this facility to ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal and US Food Codes and HACCP guidelines. 2.c. Refrigerator, food should be dated, labeled and sealed. 3.c. Freezers, Items should be labeled and dated. Staff shall adhere to safe hygienic practices to prevent contamination of foods from hands or physical objects. d. Dietary staff must wear hair restraints (e.g., hairnet, hat, and/or beard restraint) to prevent hair from contacting food .Record review of the Food and Drug Code dated 2022 indicated.3-602 Labeling3-602.11 Food Labels.(A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified inLAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, markingdevices, and containers.(B) Label information shall include:(1) The common name of the FOOD, or absent a common name, anadequately descriptive identity statement; 3-201.11 Compliance with Food Law. (C) PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9CFR 381 Subpart N Labeling and Containers, and as specified under S 3-202.18

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 4 residents (Resident's #2 and #3) and 2 of 5 staff (CNA B and LVN G) reviewed for infection control. 1.The facility failed to ensure CNA B changed gloves and washed or sanitized her hands when providing care to Resident #2 on 8/12/2025.2. The facility failed to ensure LVN G changed gloves and washed or sanitized her hands during wound care to Resident #3 on 08/12/2025.These failures could place residents at risk of exposure to infectious diseases due to improper infection control practices.Findings included: 1. Record review of a Resident Face Sheet for Resident #2 dated 8/12/2025 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of schizoaffective disorder (a mental illness that can cause hallucinations and delusions), atherosclerotic heart disease (plaque buildup that causes narrowing and limited blood flow in the blood vessels), and polyosteoarthritis (joint stiffness and pain in multiple areas). Record review of Resident #2's Quarterly MDS assessment dated [DATE] indicated she had moderate impairment in thinking with a BIMS score of 11. She required substantial/maximal assistance with personal hygiene and was always incontinent of bowel/bladder.Record review of a care plan for Resident #2 dated 12/31/2024 indicated she had a self-care deficit related to schizoaffective disorder with intervention for two staff to assist with bed mobility.During an observation on 8/12/2025 at 10:18 AM, CNA B was in the room of Resident #2 to provide incontinent care. She sanitized her hands and donned (put on) gloves. She pulled the bed linens down to the foot of the bed and opened Resident #2's brief and pulled it in between her thighs. CNA B had supplies in a plastic bag that were on an overbed table. She removed wipes from the plastic bag and wiped Resident #2's abdomen and down both inner thighs with a wipe and placed it inside the brief. She removed another wipe and wiped down the middle from front to back and placed the wipe inside the dirty brief. Resident #2 was rolled onto her left side, and CNA B removed a wipe and wiped the resident's rectal area from front to back. She rolled the dirty brief under the resident's back and placed a clean brief under the resident's buttocks. She rolled the resident to her right side and removed the brief and placed it in the trash. She removed another wipe and wiped the rectal area again and placed the wipe in the trash. She applied barrier cream to the perineal area and secured the clean brief. Resident was covered back up with the linens. CNA B removed the glove from her right hand and placed it in her left hand and grabbed the bed control and repositioned the bed in a low position. She removed the glove from her left hand and placed both gloves in the trash. She exited the room and took the trash to the dirty linen closet and sanitized her hands. During an interview on 8/12/2025 at 10:20 AM, CNA B said she had been employed at the facility since April 2025. She said during the care provided to Resident #2 she should have changed her gloves when she changed tasks from dirty to clean. She said she was nervous and forgot to change her gloves. She said she had been trained to change gloves when changing from dirty to clean and to sanitize or wash hands between glove changes. She said there was a risk for contamination if staff did not change gloves or sanitize their hands between gloves changes. Record review of a CNA Proficiency Audit for CNA B dated 5/7/2025 indicated she was satisfactory with female perineal care and infection control awareness.2. Record review of a face sheet for Resident #3 dated 2/20/2025 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of Cerebral Infraction (stroke), Muscle Weakness, Non-pressure chronic ulcer of other part of left lower leg (wound), Hemiplegia and hemiparesis (paralyzed on one side of the body).Record review of a Quarterly MDS Assessment for Resident #3 dated 6/13/2025 indicated he had severe cognitive impairment with a BIMS score of 5. He was dependent on staff for personal hygiene. He had an indwelling catheter and was always incontinent of bladder/bowel. Record review of a care plan for Resident #3 dated 1/13/2025 indicated he had an impaired cognitive deficit with interventions for skin care: Nursing staff will monitor skin and keep clean and dry as possible.Record review of physician's orders for Resident #3 dated 7/10/2025 indicated an order for wound care to his left posterior (back) knee to clean with normal saline/wound cleanser, apply collagen powder (a substance that is used to promote skin growth) and cover with a primary dressing daily.During an observation on 8/12/2025 at 2:38 PM in the room of Resident #3 LVN G and CNA C were present. There was a PPE container on the outside of the door that consisted of gowns and gloves. Prior to entering Resident #3's room LVN G and CNA C sanitized their hands and put on PPE

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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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. Based on observations, interviews, and record reviews, the facility failed to ensure it formulated, adopted, and enforced policies regarding smoking, smoking areas, and smoking safety that also consider non-smoking residents for 1 of 2 smoking areas (secured unit smoking area) reviewed for smoking safety. The facility failed to ensure paper and plastic trash were not discarded into the fire safety can on 8/12/2025. This failure could place residents at risk of injury, burns, and an unsafe smoking environment.Findings included:During an observation and interview on 8/12/2025 at 9:00 am the red fire can in the smoking area located on the secured unit was observed with a plastic liner, cigarette butts and plastic and paper trash. CNA A was outside with a resident and said everyone was responsible for the smoking area and was unsure who would have put a liner in the can, but the trash was probably placed by other staff and residents. She said the red fire can should only have cigarette butts because of fires. During an interview on 8/12/2025 at 9:20 am the Maintenance Director said he was new and was not sure who was responsible for the fire cans in the smoking area but would find out. He said he was not sure if a liner and trash should be in the fire can but could see that it could be a fire hazard. During an interview on 8/12/2025 at 4:00 pm the Administrator said that the designated smoking areas were to be maintained by the Maintenance Director but all staff that assisted the residents to smoke should be mindful of the ashtrays and fire cans and ensure there was no trash or plastic liner in the red fire can. She said the Maintenance Director was new in his position and would see that he was trained on the smoking policy and maintenance of the smoking areas. She said that by not maintaining the smoking area fires could happen.Record review of an undated facility policy titled Resident Smoking Policy indicated, .It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and non-smoking residents. 3. Safety measures for the designated smoking area will include, but are not limited to: c. Accessible metal containers with self-closing covers into which ashtrays can be emptied .