STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455895	A. Building B. Wing	11/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Five Points at Lake Highlands Nursing and Rehab	9009 White Rock Tr Dallas, TX 75238

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 37193 Based on observations, interviews and record review the facility failed to ensure each resident received adequate supervision to prevent accidents for 2 (Resident #11 and Resident #81) of 2 residents reviewed for accidents, hazards, and supervision. 1. The facility failed to ensure safe smoking for Resident #11 when he had a lighter and a pack of cigarette in his possession. 2. The facility failed to ensure safe smoking for Resident #81 when he had a lighter and a pack of cigarettes in his possession. This failure could place residents at risk for injury, burns and an unsafe smoking environment. Findings include: 1. Record review of Resident #81's face sheet dated 11/07/23 indicated Resident #81 was a [AGE] year-old male, with an original admission to the facility on [DATE] and readmitted on [DATE]. Resident #81 had diagnoses which included dementia (group of symptoms affecting memory, thinking and social abilities) alcohol dependence, tobacco use, major depression, and difficulty in walking. Record review of Resident #81's annual MDS assessment dated [DATE] indicated Resident #81 was understood and understood others. Resident #81 had no difficulty hearing and had clear speech. Resident #81 had a BIMS score of 15 which indicated intact cognition. Resident #81 required supervision with activities of daily living, and he was independent. Review of Resident #81 care plan did not address smoking. Observation on 11/05/23 at 09:42 AM revealed residents at the back entrance near the door smoking and there was no supervision from the staff. Observation on 11/05/23 at 11:38 AM revealed there were three residents who were in the wheelchair, and they were smoking on the outside of the back entrance. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 11/05/23 at 02:08 PM, revealed Resident #81 walking back to his room. He was well groomed, and he was appropriately dressed. In an interview with Resident #81 he stated he was coming back from smoking. Resident #81 stated he could go outside anytime and smoke, there was no set time for smoking. He then pulled the cigarettes and lighter from his chest pocket. Resident #81 stated he kept his lighter and cigarettes on top of the bedside nightstand. Resident #81 stated he was aware the facility was a smoke free facility, and no one had taken the cigarettes from him, and he was not informed he would be discharged due to his smoking. Resident #81 stated he smoked at the entrance of the back entrance door and there was no staff supervision when the residents smoked. In an interview with LVN E on 11/05/23 at 11:40 AM, she stated she did not know the residents who were smoking outside because they were from other halls. LVN E stated there were residents in her hall who smoked, there was no scheduled time to smoke, and the residents kept their lighters and cigarettes. LVN E stated there was no resident supervision when they smoked, the residents were supposed to sign out when they went to smoke but they did not. There was no designated staff who was to make sure the residents signed out when they left to go smoke. 2. Record review of Resident #11's face sheet, dated 11/07/23, indicated Resident #11 was a [AGE] year-old male, with an original admitted [DATE] and readmission on 10/27/22. Resident #11 had diagnoses which included type 2 diabetes mellitus (to a group of diseases that affect how the body uses blood sugar (glucose)) need for assistance for personal care, muscle weakness and pain. Record review of Resident #11's annual MDS assessment dated [DATE] indicated Resident #11 was understood and understood others. Resident #81 had no difficulty hearing and had clear speech. Resident #11 had a BIMS score of 14 which indicated intact cognition. Resident #11 required assistance with activities of daily living. Observation and interview on 11/06/23 at 03:42 PM with Resident #11 revealed he was resting in bed. He was well groomed, and he was appropriately dressed. Resident #11 stated he smoked couple of times per day whenever he felt like. He stated there was no set time for smoking. Resident #11 stated he kept his lighter and cigarettes in his bedside nightstand, and when he opened the drawer the lighter and pack of cigarettes were inside. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 11/05/23 at 02:57 with the DON she stated she had worked two years in the facility. The facility had been non-smoking since before she started working two years ago. The DON stated during the admission the residents were informed the facility was non-smoking. If the resident came to the facility, then they chose not to smoke and if they were found smoking in the facility the family was informed to pick up the cigarettes. If the resident was found to have smoked paraphernalia or smoking, they were educated an asked for their smoking items, if they refused the family was asked to come get the items. The DON observed Residents #81 & #11 smoke. The DON stated Resident #81 gave her his cigarettes and the lighter around August 2023. The DON revealed social services and nursing followed up to ensure the residents remained free of smoking. The DON stated if any resident wanted to smoke, they had to go to the boundary at the back side of the facility. The DON stated they had 19 residents who smoked. The DON stated the facility did not have a smoking policy because it was a non-smoking facility. The DON revealed the residents were offered the nicotine patch upon admission to stop smoking. The DON stated when the residents who smoked wanted to smoke, they had to sign out and sign back in, when the residents signed out the facility was not liable, she further stated any resident who went outside without signing out the nurse was to get the book and have the resident sign. The DON revealed no incidents related to smoking had been reported. The DON revealed a resident that was continually non-complainant would be offered a discharge notice but none of the residents had been given the discharge notice. In an interview on 11/05/23 at 5:08 PM with Administrator, he stated the facility was a non-smoking facility. The Administrator revealed during admission the hospital case manager informed the resident at the hospital the facility was a non-smoking place. The Administrator stated the previous administrator had the residents who smoked go to the front of the property street where it is was dangerous, so the facility set a section in the back of the facility where they were to smoke. The Administrator stated there were 19 smokers, who had their own cigarettes, and the facility did not keep the residents' cigarettes. The Administrator revealed the residents were educated of risks of smoking but did not have records for the teaching, the Administrator stated the facility was a non-smoking facility and if a resident wanted to step out of the facility to smoke, they were to sign out and they were on their own. The Administrator revealed there was no designated time or location for a resident to go outside. The Administrator revealed his expectation was to fix the supervision during smoking. He stated there was no smoking policy although there were residents in the facility who smoked because the facility was a smoke free facility.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193 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 restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal pharyngeal ulcers for one of 3 residents (Resident #7) reviewed for enteral nutrition. LVN D failed to check for residual volume prior to medication administration. This failures could place residents at risk for metabolic abnormalities, medical complications, or a decline in health. Findings included: Record review of Resident #7's face sheet, dated 07/07/23, reflected a [AGE] year-old female who originally admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included Gastrostomy status (an opening in the stomach at the abdominal wall made surgically to introduce food), dysphasia (speech disorder) and cerebral palsy (damage that occurs to the developing brain, most often before birth). Record review of Resident #7's annual MDS Assessment, dated 05/03/23, reflected Resident #7 BIMS score was blank which indicated severe cognitive impairment. Resident #7 required extensive to total assistance with ADLs with two persons assist. Further review revealed Resident #7 had a feeding tube. Record review of Resident #7's medication administration and treatment record reflected there was no specific order for checking for residual. Enteral Feed Order every shift Head of Bed raised 30 to 45 degrees during Administration of Enteral formula, Water or Medication. Observation on 11/06/23 at 09:48 AM revealed LVN D administered medication through the feeding tube. LVN D got the following medications ready: Vitamin C 500 mg 1 tablet. Vitamin B-12 1000 mcg 1 tablet, Ferrous Sulfate 325 mg 1 tablet, Folic acid 800 mcg 1 tablet, Lactulose solution 30 cc, Furosemide 20 mg 1 tablet, Ibuprofen 800 mg 1 tablet. Staff crushed medication and mixed with water. The resident feeding tube was infusing, and she paused the feeding tube and then disconnected the feeding tube from the resident and flushed with 20cc of water. Administered medication and flushed after. In an interview on 11/06/23 at 10:15 AM with LVN D she stated regarding checking resident residual, she stated she forgot, and she was supposed to check to make sure the resident did not have more than the recommended amount which could lead to aspiration or vomiting. LVN D stated there were parameters that the staff were supposed to follow when checking for residual, and if the resident had more than the recommended amount, she was supposed to inform the primary care provider and hold any infusion. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/07/23 at 03:20 PM with the DON she stated LVN D was supposed to check the resident residual before medication administration to make sure the resident was not being overfed which could lead to aspiration and vomiting. The DON stated the nurse was in-serviced on medication administration. Record reviewed of the in-service provided on medication administration, Record review of the facility policy dated 01/25/13 and titled Enteral Medication Administration reflected, Check the placement of the tube by aspiration of contents or auscultation. Elevate the resident per facility policy.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193 Based on observation, interview, and record review the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 11%, based on three out of 27 opportunities, which involved 2 of 5 residents (Resident #7 and Resident #75) reviewed for medication errors. 1. LVN D failed to administer medications as ordered to Resident #7 by administering Vitamin B-12 1000 mcg instead of Vitamin B-12 500 mg and administered Folic acid 800 mcg instead of 1mg. 2. LVN D failed to administer medication as ordered to Resident #75 by administering Levemir 18 units instead of Lantus 18 units. These failures could place residents at risk of not receiving the desired therapeutic effect of their medications and uncontrolled pain. Findings include: 1. Record review of Resident #75's face sheet, dated 07/07/23, reflected a 71-years old female who was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident #75 had diagnoses which included: reduced mobility, muscle waiting, depression, anxiety, and morbid obesity. Record review of Resident #75's significant change MDS assessment, dated 08/04/23, reflected Resident #75 had a BIMS score of 15 indicating no impairment and required extensive assistance with activities of daily living. Record review of Resident #75's November 2023 MAR reflected Resident #75's had the following medication scheduled for 8:00 AM. Insulin Glargine 18 units, Metoprolol ER 5mg, Sertraline 80 mg, Letrozole 2.5 mg, Gabapentin 100 mg, Cardizem 120 mg, MiraLAX 17 gm, Vitamin C 250mg, Eliquis 5 mg and Vilanterol Inhalation. An observation on 11/06/23 at 09:35 AM revealed LVN D administered the following medications to Resident #75; Levemir - 18 units - administered to the left deltoid, Metoprolol 50 mg ER 1 tablet, Sertraline 80 mg 1 tablet, Letrozole 2.5 mg 1 tablet, Gabapentin 100 mg 1 tablet, Cardizem 120 mg 1 tablet, MiraLAX 17 gm, Docusate 100 mg 1 tablet, Vitamin C 250 mg 1 tablet, Eliquis 5 mg 1 tablet, Ferrous Sulfates 325 mg 1 tablet, Vilanterol Inhalation 2. Record review of Resident #7's face sheet, dated 07/07/23, reflected a [AGE] year-old female who was originally admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included Gastrostomy status (an opening in the stomach at the abdominal wall made surgically to introduce food), dysphasia (speech disorder), and cerebral palsy (a group of disorders that affect movement, muscle tone, balance, and posture). (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #7's annual MDS Assessment, dated 05/03/23, reflected Resident #7 had a BIMS score which was blank, which indicated severe cognitive impairment. Resident #7 required extensive to total assistance with ADLs with two persons assist. Further review reflected Resident #7 had a feeding tube. Record review of Resident #7's medication administration record reflected Resident #7 had the following mediations scheduled at 8 am; Vitamin C 500 mg, Vitamin B-12 1000 mcg, Ferrous sulfate 325 mg, Folic acid 800 mcg, lactulose solution 30 cc, furosemide 20 mg and Ibuprofen 800 mg. Observation on 11/06/23 at 09:48 AM revealed LVN D administered the following medications to Resident #7 via the feeding tube; Vitamin C 500 mg 1 tablet, Vitamin B-12 1000mcg 1 tablet, Ferrous Sulfate 325 mg 1tablet, Folic acid 800 mcg 1 tablet, Lactulose solution 30cc, Furosemide 20 mg 1 tablet and Ibuprofen 800 mg 1 tablet In an interview on 11/06/23 at 02:57 PM with LVN D, regarding medication administration she stated she was supposed to follow the five rights of medication administration: patient, dose, medication, route, and time. LVN D stated she realized she administered the wrong insulin to Resident # 75, so she called the pharmacy and ordered the right medication (Lantus). LVN D stated she was supposed to administer Lantus to Resident #75 instead she administered Levemir. LVN D stated both were long-acting insulin. Regarding Resident #7 physician order review the resident was supposed to take Vitamin B-12 500 mcg and Folic acid 1 mg. LVN D stated she did not realize she had not administered the correct dose for Vitamin B-12 and Folic acid to Resident #7. LVN D stated administering the wrong dose of medication could lead to adverse health effects and even death. In an interview on 11/07/23 at 03:20 PM with the DON she stated staff were supposed to make sure during medication administration they administered the right dose and the right medications. The DON stated the staff were to follow the rights of medication administration to prevent medication error and adverse effects from the wrong medications. The DON stated the Pharmacy consultant completed medication pass with the charge nurses monthly. The facility completed medication administration in-service in August or September. Record review of the facility policy, revised on 10/25/17, and titled Medication Administration Procedures reflected, 20. The 10 rights of medication should always be adhered to 1. Right patient 2. Right medication 3. Right dose 4. Right route 5. Right time 6. Right patient education 7. Right documentation (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. Right to refuse 9. Right assessment 10. Right evaluation NOTE: Any deviation from specified and recommended procedures in dispensing or administering medications to the resident requires documented approval by the Quality Assurance Committee and shall be in concurrence with current statutes and regulations.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193 Based on observation, interview, and record review, 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 one of five residents (Resident #152) reviewed for infection control. 1. CNA A failed to complete hand hygiene while providing incontinent care to Resident #152. 2. The facility failed to ensure linens and trash were not on the floor in Resident #152's room and bathroom. These failures could place residents at risk for contamination and infection and foul smell in the rooms. The findings include: 1. Observation on 11/05/23 at 09:35 AM revealed there were linens on the floor and trash on the floor in room [ROOM NUMBER] and there was foul smell in the room. Observation on 11/05/23 at 12:50 PM revealed there were linens and a used brief on the floor in the bathroom. CNA A was in the bathroom collecting the linens. The bathroom was not a public bathroom. In an interview on 11/05/23 at 09:38 AM with LVN B who was in the room, she stated she also saw the linens and she was not aware why the linens were on the floor. She stated the linens were not supposed to be on the floor due to infection control. The linens and dirty brief were supposed to be placed in a trash bag then taken to the dirty linen room. In an interview on 11/05/23 at 12:54 PM with CNA A she stated the linens were not supposed to be on the floor. CNA A stated the linens and trash were on floor because she forgot to bring trash bags when she was providing care to Resident #52. CNA A stated the linens were not supposed to be on the floor because of infection control. 2. Observation on 11/07/23 at 11:22 AM revealed CNA C was providing incontinent care to Resident #152. CNA C entered the resident's room and donned gloves and, then informed the resident she was going to get him ready and dressed so he could get up. CNA C then repositioned the resident and unfastened the residents brief and cleaned the resident. The staff was changing the gloves, but she did not complete hand hygiene. After cleaning and dressing the resident, she removed her gloves off and left the room. CNA C stated she was going to get the sit to stand lift. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/07/23 at 11:30 AM with CNA C, she stated she worked in business office, and she was an aide as well. CNA C stated she was supposed to complete hand hygiene when changing gloves, but she did not because there was no hand sanitizer in the room, she stated they were not allowed to have hand sanitizer the pockets. Asked about washing hands with water and soap in the room, she stated yes I could have. CNA C stated she completed hand hygiene before and after care and she did not complete hand hygiene during care. CNA C stated she could have washed her hands in the bathroom. CNA C stated she was supposed to complete hand hygiene during care to prevent cross contamination. In interview on 11/07/23 at 03:29 PM with the DON, she stated the staff were supposed to complete hand hygiene with every change of gloves. The DON also stated no linens or soiled briefs were supposed to be left in the rooms because this could leave a foul smell in the room. CNA C was supposed to complete hand hygiene to prevent infection control. Record review of the facility policy updated 03/23, and titled, Infection Control Plan: Overview reflected, Infection Control The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection . Linens Personnel will handle, store, process and transport linens so as to prevent the spread of infection. Record review of the facility's, undated, Hand Hygiene policy reflected, You may use alcohol-based hand cleaner or soap/water for the following: - After removing gloves or aprons - After completing duty.

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193 Based on observation, interview and record review, the facility failed to establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas and smoking safety that also took into account nonsmoking residents for 2 of 2 residents (Resident #11, Resident #81) reviewed for safe smoking. The facility failed to develop a policy to address residents signing in and out on a Release of Responsibility for Leave of Absence form to smoke, which included Resident #11 and Resident #81. This failure could place residents at risk for injury, burns and an unsafe smoking environment. Findings include: 1. Record review of Resident #81's face sheet dated 11/07/23 indicated Resident #81 was a [AGE] year-old male, with an original admission to the facility on [DATE] and readmitted on [DATE]. Resident #81 had diagnoses which included dementia (group of symptoms affecting memory, thinking and social abilities) alcohol dependence, tobacco use, major depression, and difficulty in walking. Record review of Resident #81's annual MDS assessment dated [DATE] indicated Resident #81 was understood and understood others. Resident #81 had no difficulty hearing and had clear speech. Resident #81 had a BIMS score of 15 which indicated intact cognition. Resident #81 required supervision with activities of daily living, and he was independent. Review of Resident #81 care plan did not address smoking. Observation on 11/05/23 at 09:42 AM revealed residents at the back entrance near the door smoking and there was no supervision from the staff. Observation on 11/05/23 at 11:38 AM revealed there were three residents who were in the wheelchair, and they were smoking on the outside of the back entrance. Observation and interview on 11/05/23 at 02:08 PM, revealed Resident #81 walking back to his room. He was well groomed, and he was appropriately dressed. In an interview with Resident #81 he stated he was coming back from smoking. Resident #81 stated he could go outside anytime and smoke, there was no set time for smoking. He then pulled the cigarettes and lighter from his chest pocket. Resident #81 stated he kept his lighter and cigarettes on top of the bedside nightstand. Resident #81 stated he was aware the facility was a smoke free facility, and no one had taken the cigarettes from him, and he was not informed he would be discharged due to his smoking. Resident #81 stated he smoked at the entrance of the back entrance door and there was no staff supervision when the residents smoked. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with LVN E on 11/05/23 at 11:40 AM, she stated she did not know the residents who were smoking outside because they were from other halls. LVN E stated there were residents in her hall who smoked, there was no scheduled time to smoke, and the residents kept their lighters and cigarettes. LVN E stated there was no resident supervision when they smoked, the residents were supposed to sign out when they went to smoke but they did not. There was no designated staff who was to make sure the residents signed out when they left to go smoke. 2. Record review of Resident #11's face sheet, dated 11/07/23, indicated Resident #11 was a [AGE] year-old male, with an original admitted [DATE] and readmission on 10/27/22. Resident #11 had diagnoses which included type 2 diabetes mellitus (to a group of diseases that affect how the body uses blood sugar (glucose)) need for assistance for personal care, muscle weakness and pain. Record review of Resident #11's annual MDS assessment dated [DATE] indicated Resident #11 was understood and understood others. Resident #81 had no difficulty hearing and had clear speech. Resident #11 had a BIMS score of 14 which indicated intact cognition. Resident #11 required assistance with activities of daily living. Observation and interview on 11/06/23 at 03:42 PM with Resident #11 revealed he was resting in bed. He was well groomed, and he was appropriately dressed. Resident #11 stated he smoked couple of times per day whenever he felt like. He stated there was no set time for smoking. Resident #11 stated he kept his lighter and cigarettes in his bedside nightstand, and when he opened the drawer the lighter and pack of cigarettes were inside. In an interview on 11/05/23 at 02:57 with the DON she stated she had worked two years in the facility. The facility had been non-smoking since before she started working two years ago. The DON stated during the admission the residents were informed the facility was non-smoking. If the resident came to the facility, then they chose not to smoke and if they were found smoking in the facility the family was informed to pick up the cigarettes. If the resident was found to have smoked paraphernalia or smoking, they were educated an asked for their smoking items, if they refused the family was asked to come get the items. The DON observed Residents #81 & #11 smoke. The DON stated Resident #81 gave her his cigarettes and the lighter around August 2023. The DON revealed social services and nursing followed up to ensure the residents remained free of smoking. The DON stated if any resident wanted to smoke, they had to go to the boundary at the back side of the facility. The DON stated they had 19 residents who smoked. The DON stated the facility did not have a smoking policy because it was a non-smoking facility. The DON revealed the residents were offered the nicotine patch upon admission to stop smoking. The DON stated when the residents who smoked wanted to smoke, they had to sign out and sign back in, when the residents signed out the facility was not liable, she further stated any resident who went outside without signing out the nurse was to get the book and have the resident sign. The DON revealed no incidents related to smoking had been reported. The DON revealed a resident that was continually non-complainant would be offered a discharge notice but none of the residents had been given the discharge notice. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455895	A. Building B. Wing	11/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Five Points at Lake Highlands Nursing and Rehab	9009 White Rock Tr Dallas, TX 75238

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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 - Some	In an interview on 11/05/23 at 5:08 PM with Administrator, he stated the facility was a non-smoking facility. The Administrator revealed during admission the hospital case manager informed the resident at the hospital the facility was a non-smoking place. The Administrator stated the previous administrator had the residents who smoked go to the front of the property street where it is was dangerous, so the facility set a section in the back of the facility where they were to smoke. The Administrator stated there were 19 smokers, who had their own cigarettes, and the facility did not keep the residents' cigarettes. The Administrator revealed the residents were educated of risks of smoking but did not have records for the teaching, the Administrator stated the facility was a non-smoking facility and if a resident wanted to step out of the facility to smoke, they were to sign out and they were on their own. The Administrator revealed there was no designated time or location for a resident to go outside. The Administrator revealed his expectation was to fix the supervision during smoking. He stated there was no smoking policy although there were residents in the facility who smoked because the facility was a smoke free facility.