STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455959	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westward Trails Nursing and Rehabilitation	3001 Westward Dr Nacogdoches, TX 75964

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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** 40124 46436 Based on observations, interviews, and record review, the facility failed to ensure that each resident had a right to privacy during medical care for 1 of 25 residents (Residents #13) observed for privacy. The facility failed to ensure full visual privacy during incontinent care for Resident #13 on 04/22/2024. This deficient practice placed residents at risk of loss of privacy and dignity. The findings were: Record review of a facility face sheet dated 04/23/2024 indicated Resident #13 was a [AGE] year-old female and admitted to the facility on [DATE] with a diagnosis of end stage renal disease (inability of the kidneys to filter waste), diabetes (high glucose content in the blood), and morbid obesity. Record review of a quarterly MDS assessment dated [DATE] indicated Resident #13 had a BIMS score of 12 indicating cognition was mildly impaired and was incontinent of urine and bowel requiring total assistance with toileting. Record review of the care plan dated 02/12/2024 indicated Resident # 13 had an ADL (activity of daily living) function disorder and to assist with ADLs as needed. During an observation of incontinent care on 04/22/2024 at 9:43 am this state surveyor knocked on the door and asked permission to enter. Permission was granted. The privacy curtain was not pulled around Resident #13. Resident #13 was unclothed from the neck down exposing her breasts and her legs spread apart. Resident # 13 was being prepared for incontinent care by CNA A and CNA H. During an observation and interview on 04/22/24 at 10:00 am outside of Resident #13's window, a male worker was cutting grass and picking up the lawn. Midway into the care with resident unclothed CNA A saw the workers and said oh I've done it again. She closed the blind and said oh I should have closed it before I started. CNA H then drew the privacy curtain around Resident #13. (continued on next page)

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/22/24 at 1:30 pm Resident #13 said she never realized the blinds were up and the curtain was not pulled. She said not providing privacy could embarrass some residents. Resident #13 said she had been through a lot of things, and it really did not affect her. During an interview on 04/22/2024 at 12:00 pm the DON said she was very disappointed that CNA A did not follow the proper procedure for privacy. She said if privacy was not maintained, and a resident was exposed during personal care it could cause embarrassment. During an interview on 04/23/2024 at 3:20 pm the Administrator stated he expected everyone in the facility to be trained, follow resident rights, treat all residents with dignity, and maintain privacy . She stated by not doing so could cause resident embarrassment. During an interview on 04/24/2024 at 8:33 am the ADON said she was responsible for competency checks for the nurses and aides. She said that CNA A had been trained on resident rights to include providing privacy during personal care by closing the window covering, pulling the curtain, and closing the door to the room. She said if privacy was not maintained, and a resident was exposed during personal care it could cause embarrassment . Record review of an undated facility policy titled Resident Rights indicated, The resident has a right to a dignified existence, self-determination . Record review of a facility policy titled Personal Care dated 5/11/2022 indicated, .prepare: 7). provide privacy and modesty by closing the door and/or curtain .

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on interviews and record review, the facility failed to complete a significant change MDS assessment within 14 days after a significant change in the resident's mental and physical condition for 1 of 6 residents (Resident #4) reviewed for assessments. The facility failed to reassess Resident #4 following a hospice admission (specific care for the sick or terminally ill) on 12/15/2023. This failure could place residents at risk for not having their individual needs met due to inaccurate assessments. The findings included: Record review of a face sheet for Resident #4 dated 4/23/2024 indicated he admitted to the facility 9/3/2013 and was [AGE] years old with diagnosis of parkinsonism (brain condition that causes slowed movements, stiffness, and tremors), schizoaffective disorder, bipolar type (delusions with mood swings and depression), mild intellectual disabilities (slower in areas of thinking and development of social and daily living skills), and hypertension (high blood pressure). Record review of active physician orders dated 4/23/2024 for Resident #4 indicated an order to admit to hospice services with a start date of 12/15/2023. Record review of a Quarterly MDS Assessment for Resident #4 dated 1/5/2024 indicated he had significant impairment in thinking with a BIMS score of 3. Special Treatments and Procedures did not indicate he was on hospice services in the 14 days look back period. Record review of a care plan dated 10/23/2023 for Resident #4 indicated he had hospice services as evidenced by terminal illness with a diagnosis of senile degeneration of the brain. Interventions included: Assist with ADLS and provide comfort measures as needed. During an interview on 4/23/2024 at 12:20 PM, MDS Coordinator D and MDS Coordinator E both said Resident #4 admitted to hospice services on 10/20/2023 and did not know why his orders showed 12/15/2023. MDS Coordinator E said the previous MDS Coordinator would have been responsible for completing a significant change MDS Assessment for Resident #4 but was no longer employed at the facility. They both said the significant change MDS assessment should have been done on the day of admission to hospice services and should have been completed within 7 days. MDS Coordinator E said during the morning meetings they discussed any residents with significant changes such as declines or improvements, admission to hospice, or residents discharging from hospice, and was not aware that Resident #4 did not have a significant change MDS assessment. MDS Coordinator E said residents could be at risk of the state not being aware of changes and it affected everything. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/24/2024 at 9:50 AM, the DON and Administrator both said the MDS Coordinators were responsible for the resident assessments. The DON said she only signed the MDS assessments and the MDS Coordinators were responsible for accuracy. Both said they discussed significant changes in the morning meetings and there was a discussion about Resident #4 at the time he was admitted to hospice. Both said they were not sure how his significant change MDS assessment was missed. Going forward, the DON said she would question any significant changes and the residents could be a risk of not getting needed services. Record review of a facility policy titled Resident Assessment undated indicated, .1. A comprehensive assessment will be completed within 14 days of admission and annually on each resident. The facility will utilize the Resident Assessment Instrument (RAI). 3. RAI assessments must be conducted within 14 days after the date of admission; promptly after a significant change in the resident's physical or mental condition (as soon as the resident stabilizes at a new functional or cognitive level, or within two weeks, whichever is earlier) .

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on interviews and record review, the facility failed to refer all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change of condition for 1 of 6 Residents (Resident #32) reviewed for PASSAR (Preadmission Screening and Resident Review Services). The facility failed to ensure Resident #32 had a new level 1 PASSAR completed with a new diagnosis of Post-Traumatic Stress Disorder (a mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback, and avoidance of similar situations) and major depressive disorder (persistent feeling of sadness and loss of interest that interferes with daily life). These failures could place residents at risk of not receiving the needed PASSAR services to meet their individual needs and could result in a decreased quality of life. The findings were: Record review of a face sheet dated 4/23/2024 for Resident #32 indicated she admitted to the facility on [DATE] and was a [AGE] year old female with diagnoses of Huntington's disease (an inherited condition in which the nerve cells in the brain break down over time), post-traumatic stress disorder (a mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback, and avoidance of similar situations), major depressive disorder with psychotic symptoms (persistent feeling of sadness and loss of interest that interferes with daily life), and heart failure. Record review of a Quarterly MDS assessment dated [DATE] for Resident #32 indicated she had moderate impairment in thinking with a BIMS score of 8. She had active diagnoses that included psychiatric/mood disorders of anxiety disorder, depression, and post-traumatic stress disorder (PTSD) during the 7 days look back period. There was no referral made to the local contact agency because the discharge date was more than 3 months away. Record review of a PL1 dated 9/27/2021 for Resident #32 indicated she was positive for mental illness. Record review of a PE dated 9/28/2021 for Resident #32 indicated she did not meet the definition of mental illness. Record review of a care plan dated 7/1/2021 revised on 2/5/2024 for Resident #32 indicated she had depression related to diagnosis of major depressive disorder with interventions to administer medications as ordered, monitor/record/report to MD prn risk for harm to self, pharmacy review monthly or per protocol, and psych services as indicated. PTSD was not care planned for Resident #32. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/23/2024 at 12:20 PM, MDS Coordinator D and MDS Coordinator E both said they were not aware that Resident #32 had new diagnosis of mental illness that included PTSD or major depressive disorder. They both said if a resident was a new admission, then the nursing department, and MDS Coordinators were responsible for entering the diagnosis. They said the ADON's were responsible for adding new diagnosis after admission to the facility. They both said Resident #32 received a new diagnosis of PTSD and major depressive disorder from the psychiatric doctor. MDS Coordinator D said going forward they would submit a new PL1 for Resident #32 today (4/23/2024), would get the form 1012 signed, and contact the local authority. MDS Coordinator D said she started as one of the MDS coordinators for the facility on March 11, 2024. MDS Coordinator E stated she had been employed at the facility since 2021. They stated neither one of them were aware that Resident #32 had new mental illness diagnosis. Both said residents could be at risk of missing services that they needed if they were not aware of a new diagnosis. Record review of a Mental Illness/dementia Resident Review Form 1012 dated 4/23/2024 by MDS Coordinator D for Resident #32 indicated the resident did not have a dementia diagnosis but did include diagnosis of mood disorder dated 2/19/2022 and PTSD dated 2/19/2022. If any of the responses were answered as yes, the nursing facility needed to complete a new PL1 and a full PASSR Evaluation would be conducted after the nursing facility submitted the new positive PL1. The form had not been signed by the physician. During an interview on 4/24/2024 at 9:30 AM, the DON and Administrator said the MDS Coordinators were responsible for PASSR coordination. They both said during the care plan meetings they talked about psychiatric visits and anything that was new or needed to be updated. Both said they were not aware that Resident #32 did not have a new PL1 completed and it should have been completed after the new mental illness diagnosis was added. The DON said she had training on PASSR in the past but was not too familiar with the process. Both said going forward at each care plan meeting they would review new diagnoses. Both said residents could be at risk of not getting all the support and help they needed and it could worsen their mental health. Record review of a facility policy titled PASRR Level 1 Screen Policy and Procedure revised 3/6/2019 indicated, .PASRR is a federally mandated program requiring all states to prescreen all individuals seeking admission to a Medicaid-certified nursing facility. The PASRR program has 3 goals: 1. To identify individuals with MI, ID, or DD/RC (this included adults and children); 3. To ensure individuals receive the required services for their MI, ID, or DD .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on interviews and record review, the facility failed to review and revise the person-centered care plan to reflect the current condition for 1 of 6 residents (Resident #32) reviewed for care plans. The facility failed to ensure Resident #32's care plan reflected a diagnosis of PTSD (a mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback, and avoidance of similar situations). This failure could place residents at risk of not receiving appropriate care to meet their current needs. The findings included: Record review of a face sheet dated 4/23/2024 for Resident #32 indicated she admitted to the facility on [DATE] and was [AGE] year old female with diagnoses of Huntington's disease (an inherited condition in which the nerve cells in the brain break down over time), post-traumatic stress disorder (a mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback, and avoidance of similar situations), major depressive disorder with psychotic symptoms (persistent feeling of sadness and loss of interest that interferes with daily life), and heart failure. Record review of a Quarterly MDS assessment dated [DATE] for Resident #32 indicated she had moderate impairment in thinking with a BIMS score of 8. She had active diagnoses that included psychiatric/mood disorders of anxiety disorder, depression, and post-traumatic stress disorder (PTSD) during the 7 days look back period. There was no referral made to the local contact agency because the discharge date was more than 3 months away. Record review of a care plan dated 7/1/2021 revised on 2/5/2024 for Resident #32 indicated she had depression related to diagnosis of major depressive disorder with interventions to administer medications as ordered, monitor/record/report to MD prn risk for harm to self, pharmacy review monthly or per protocol, and psychiatric services as indicated. PTSD was not care planned for Resident #32. During an interview on 4/24/2024 at 9:25 AM, both MDS Coordinators D and E said they were responsible for revising and updating the care plans. Both said they were not aware of the new diagnosis for Resident #32 that included PTSD. Both said the risk to the residents could include all members of the IDT team would not know what was going on with the resident or if any support was needed for the residents. Both said going forward the ADON would get the orders and would ensure they both were aware and update the care plans as needed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/24/2024 at 9:30 AM, the DON and Administrator said the MDS Coordinators were responsible for updating and revising the comprehensive care plans. Both said nursing were responsible for the acute care plans. They said during the care plan meetings they talked about psychiatric visits and anything that was new or needed to be updated. Both said they were not aware that Resident #32 did not have an updated care plan to include PTSD. Both said going forward at each care plan meeting they would review new diagnosis for residents. They stated residents could be at risk of not getting all the support and help needed and it could worsen their mental health. Record review of a facility policy titled Comprehensive Care Planning undated indicated, .The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives, and timeframes to meet resident needs. In addition to addressing preferences and needed assessed by the MDS, the comprehensive care plan will coordinate with and address any specialized services or specialized serviced the facility will provide or arrange as a result of PASARR recommendations.

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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** 46436 Based on observations, interviews, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 2 of 5 residents (Resident #65 and Resident #62) reviewed for transfers and accident hazards. The facility failed to ensure Resident #65 was transferred using a gait belt on 4/22/2024. The facility failed to ensure Resident #62 did not have his smoking materials that included a lighter and cigarettes in his possession on 4/22/2024 and 4/23/2024. These failures could place residents at risk of falls, injuries, and burns. The findings were: 1.Record review of a facility face sheet dated 4/23/2024 indicated Resident # 65 was a [AGE] year-old male that admitted to the facility on [DATE] with a diagnosis of fluid overload. Record review of a quarterly MDS assessment dated [DATE] indicated Resident # 65 had a BIMS of 14 indicating intact cognition and was dependent on 2 persons for transfers. Record review of a comprehensive care plan dated 3/28/2024 indicated Resident # 65 was at risk for falls and required assistance x 2 person with transfers. During an observation on 4/22/2024 at 9:13 am Resident # 65 was transferred from the bed to his electric wheelchair without using a gait belt by CNA A and CNA B. Both CNA's had a gait belt around them but placed their arms under each arm of Resident # 65 and lifted him manually to place him in his wheelchair. During an interview on 4/22/2024 at 9:25 am CNA B said she had been a CNA for 1 year and Resident # 65 was transferred as a 2 person assist and she should have placed a gait belt around him. She said she should not have handled him under the arms to prevent injuries. She said she had been properly trained on gait belt transfers and got nervous. During an interview on 4/22/2024 at 9:32 am CNA A said she had been a CNA for 2.5 years and had received training on transfer safety. She said Resident # 65 was a 2 person assist and required a gait belt for transfers for safety. She said she should have used a gait belt to prevent injury. During an interview on 4/22/2024 at 9:33 am Resident # 65 said the staff were good to him and usually used a gait belt to transfer him but he did not like the gait belt because it was uncomfortable. He said he had not told anyone that he did not want to be transferred with a gait belt but would today. He said he had not been dropped or had any injury from being transferred without a gait belt. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/24/2024 at 8:33 am the ADON said she was responsible for competency checks for the nurses and aides. She said that CNA A and CNA B were both trained on proper transfer technique using a gait belt and Resident #65 required a 2 person assist with a gait belt for all transfers. She said that by not properly transferring a resident it could cause injury. During an interview on 4/24/2024 at 9:53 am the DON said the nursing administration was responsible for oversight of all staff regarding proper transfer technique. She said all staff were trained on hire, annually, with any incident or change in status on transfers. She said that each resident has a care plan regarding their transfer status and the aides were aware of each residents transfer needs. She said that a resident that was not properly transferred could result in injury and expected all staff to transfer residents properly based on their ability. During an interview on 4/24/2024 at 10:04 am the Administrator said that transfer training was the responsibility of the nursing administration. He said he expected all staff to follow the facility's policy for transfer and safety to prevent injuries. Record review of transfer checklist dated 04/08/2024 indicated CNA A was observed and was competent on transfers. Record review of transfer checklist dated 4/09/2024 indicated CNA B had been observed and was competent on transfers. 2. Record review of a face sheet dated 4/22/2024 for Resident #62 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnosis of nicotine dependence, cigarettes, with withdrawal, atherosclerotic heart disease (clogged, blocked arteries), and peripheral vascular disease (decreased blood flow to the legs). Record review of a care plan dated 12/4/2023 for Resident #62 indicated he smoked with interventions for no smoking materials or igniter's to be stored in the resident's room. Record review of a safe smoking assessment dated [DATE] and 4/3/2024 for Resident #62 indicated he was deemed safe to smoke. Record review of a Discharge Return Anticipated MDS assessment dated [DATE] for Resident #62 indicated the brief interview for mental status was not evaluated. During an observation and interview on 4/22/2024 at 8:42 AM, Resident #62 was in his room in bed awake. He said he had been at the facility since December 2023. There were two lighters on his over bed table and a box of cigarettes. He said he was a smoker and he smoked after he ate, and staff were always with him when he went out to smoke. When asked if he could keep his smoking materials he did not answer. During an observation on 4/22/2024 at 12:34 PM, Resident #62 was pushed in his wheelchair from the dining room by staff after eating lunch to the outside area for a smoke break. One staff was present and told Resident #62 that he did not have a lighter. Resident #62 did not say anything and pulled out a cigarette and a lighter from his pocket and lit his cigarette. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/23/2024 at 9:50 AM, Resident #62 was in his room in bed and there was a lighter on his over bed table. During an interview on 4/23/2024 at 3:42 PM, CNA G said she had been employed for 6 years at the facility and was assigned to work the hall where Resident #62 resided. She said Resident #62 was a smoker and had not been at the facility long. She said they do not have anyone that can go out by themselves. She said she had seen him with cigarettes and lighter in his room a couple of times and they were taken from him. Resident #62 was fully aware that he was not supposed to have them. She said if residents kept their cigarettes and lighters, there could be a risk of a fire. During an interview on 4/23/2024 at 3:52 PM, CNA H said she had been employed at the facility for 2 years and worked the hall where Resident #62 resided. She said Resident #62 was a smoker and different staff were assigned to take the residents who smoked outside. She said they have found smoking materials that included cigarettes and a lighter last week with him, and they gave the material to the nurse to be locked up at the nurse desk. She said residents could be a risk of fire if they kept their cigarettes and lighters. During an interview on 4/23/2024 at 3:59 PM, LVN J said she had been employed at the facility for 2 years and worked the hall where Resident #62 resided. She said Resident #62 was deemed a safe smoker and knew how to light his cigarettes, but his smoking materials were kept in the medication room. She said one staff took out the residents who smoked. She said when Resident #62 first admitted to the facility, he was keeping smoking materials in his room, and it was removed. She said she was not aware that he had smoking materials in his room this week during survey. She said safe smoking assessments were completed monthly. She said if residents were allowed to keep their smoking materials on them, there was a risk of setting the facility on fire, injuring themselves, or others. Record review of a list of safe smokers undated indicated that Resident #62 was listed as a safe smoker. During an interview on 4/24/2024 at 9:50 AM, the DON and Administrator both said resident smoking materials were to be stored in the medication room and any staff could take them out to smoke. Both said Resident #62 was deemed a safe smoker and he could smoke unsupervised, but that he was not allowed to have smoking materials in his room. Both said Resident #62 has had smoking items confiscated (taken) in the past and on yesterday 4/23/2024, he had a lighter in his pocket. The DON said they have educated Resident #62 about not being able to keep smoking materials with him all the time. The DON said staff were responsible to ensure smoking materials were put back up after the resident had finished smoking. Both said going forward they would educate staff on the facility smoking policy and said residents were at risk for injuring themselves or others and there was a risk of fire in the facility if residents kept their smoking materials. Record review of a facility policy titled Moving a Resident, Bed to Chair/Chair to Bed dated 2003 indicated, . pull the cubicle curtain for privacy, if moving a resident from bed to chair, position a gait belt around the resident's waist and clasp it, if a resident requires . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westward Trails Nursing and Rehabilitation	3001 Westward Dr Nacogdoches, TX 75964

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility policy titled Uniform Smoke Free Policy undated indicated, .Smoking tobacco, matches, lighters, or other smoking paraphernalia are not permitted to be kept or stored in a residents' room. A resident who is assessed safe to smoke unsupervised, will be instructed to obtain their smoking paraphernalia from a designated, secured area. The resident will be instructed to return the smoking paraphernalia following the smoking session .

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on observations, interviews, and record review, the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and offered a therapeutic diet when there was a nutritional problem and the healthcare provider orders a therapeutic diet for 1 of 4 residents (#15) reviewed for weight loss and nutrition. The facility failed to provide Resident #15 with therapeutic meals as indicated by the physician orders for double portions on 4/22/2024 and 4/23/2024. These failures could place residents at risk for unplanned weight loss, malnutrition, and failure to thrive. The findings included: Record review of a face sheet for Resident #15 dated 4/23/2024 indicated he admitted to the facility 2/15/2024 and was [AGE] years old with diagnosis of Parkinsonism (caused by a brain condition with slowed movements and stiffness), dementia, dysphagia (difficulty swallowing), protein calorie malnutrition, and GERD. Record review of a Quarterly MDS assessment dated [DATE] for Resident #15 indicated he had significant impairment in thinking with a BIMS score of 3. He was dependent on staff with all ADL's. The swallowing/nutritional status indicated his weight in the last 30 days was 125 lbs. He had weight loss of 5% or more in the last month or loss of 10 % or more in last 6 months and was not on a physician prescribed weight loss regimen. He had mechanically altered diet while a resident during the 7 days look back period. Record review of a care plan dated 7/2/2021 and revised on 10/17/2023 for Resident #15 indicated he was at risk for malnutrition, puree diet. Interventions included double portions initiated on 2/5/2024 and offer diet as ordered by the physician initiated on 7/2/2021. He had a significant unplanned/unexpected weight loss initiated on 03/13/2024 and revised 03/15/2024 that included a goal for his weight to stabilize within 4 weeks. Interventions included double portions at all meals dated 3/25/2024. Record review of a nursing progress note dated 4/5/2024 by ADON F for Resident #15 indicated, .Res referred to dietician related to Weight loss she emailed: -He is on several medications that could be r/t wt loss (Carbidopa-Levodopa and Paxil). His Bun/Creatinine ratio (kidney function) was elevated as well as sodium which could mean some dehydration or possibly CHF (heart failure). He is already on nutritional support double portions with meals, fortified foods and snacks BID and his PO intake averages >75%. There is not much more we can do nutritionally other than start a probiotic. He does have some GI (stomach) issues and vitamin deficiencies so he would benefit from that. It's possible that wt loss is r/t to age PLUS comorbidities. I would continue to offer cuing and meal assistance along with the probiotic and make sure he is getting >1500ml fluid each day. MD gave new orders for Probiotic daily . (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of active orders dated 4/23/2024 for Resident #15 indicated a diet order for a Regular diet Pureed texture, Regular consistency, No grapefruit or grapefruit juice, Double portions at all meals. Fortified pudding lunch/dinner; Fortified milk Breakfast and dinner; fortified eggs at breakfast with a start date of 4/17/2023 after State Surveyor intervention. Record review of weight logs for Resident #15 revealed: 4/17/2024 13:49 121.0 Lbs wheelchair 4/9/2024 12:56 120.8 Lbs hoyer (mechanical lift) 4/3/2024 15:01 119.3 Lbs hoyer 3/27/2024 10:45 120.8 Lbs hoyer 3/20/2024 11:14 121.5 Lbs hoyer 3/13/2024 11:16 123.2 Lbs hoyer 3/6/2024 16:47 125.2 Lbs hoyer During an observation on 4/22/2024 at 12:45 pm in the room of Resident #15, his lunch tray card read regular, puree (smooth, pudding textured), assist with completion of meals, pudding on tray. Staff was present and assisted him to eat. His tray did not have double portions. Attempted a phone interview with a family member for Resident #15 on 4/22/2024 at 2:24 PM, left a message for a return phone call. During an observation and interview on 4/23/2024 at 12:30 PM, Resident #15 was in the dining room for lunch being assisted by staff. His tray card read regular, puree texture-assist with completion of meal. Diet observed did not have double portions on tray. The DON was in the dining room and questioned about his meal. She said it looked like there was a lot of food on his tray and verified that Resident #15 should have double portions at all meals. During an interview on 4/23/2024 at 3:42 PM, CNA G had been employed at the facility for 6 years and worked the day shift from 6am-6pm. She said she was assigned to work the hall where Resident #15 was every day she worked. She said Resident #15 had to be fed and needed total assistance with care. She said he was on a puree diet with double portions. She said sometimes she fed him at breakfast, and he had double portions and a super pudding on his tray. She said it said double portions on his tray card. She said Resident #15 always ate 100% of meals and never refused but said since his diet was puree, she noticed his weight fluctuated. She said there was always a red glass on his tray for staff to indicate weight loss that would be upside on the tray. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/23/2024 at 4:11 PM, ADON F said she had been employed in her position for a year and was responsible for weights, pharmacy recommendations, dietary recommendations, and psychiatric consents. She said Resident #15 admitted to the facility a year ago and was on several different dietary recommendations such as fortified foods, hard to gain weight, and on weight watchers at this time. She said he triggered for a weight loss 2/7/2024 at 125 lbs. and on 3/13/2024 was 123 lbs. She said on 4/5/2024 the dietician visited the facility and said Resident #15 was on several medications that could be causing his weight loss such as carbidopa/levodopa (used to treat Parkinson's disease) and Paxil (used to treat depression). She said he was on nutritional supplements along with double portions and fortified foods and the dietician suggested adding a probiotic. She said he had been on double portions for a while. She said they had a staff member designated to weigh the residents and she checked the tray cards for the residents in the dining room on Mondays-Fridays. She said if residents did not get their assigned diet orders, they could potentially lose weight During an interview on 4/24/2024 at 7:57 AM, the Cook said she had been employed at the facility for 2 years. She said she worked on yesterday (4/23/2024) but was not assigned to cook. She said today 4/24/2024 was her first time to cook and she would be the cook full time. She said there was another cook on 4/22/2024 and 4/23/2024, but he was not working today and his last day to work at the facility would be this Friday 4/26/2024. She said there were a few residents in the facility that had diet orders for double portions. She said Resident #15 did not have an order for double portions on his tray card ticket before today and was not aware if he had received double portions or not on his meal trays. She said double portions was added to the tray card this morning to indicate he would be receiving double portions. She said double portions meant that each item that was on the tray, they should have two scoops. She said residents could be at risk of losing weight if they had orders for double portions and were not provided the portion sizes and get sicker if they did not receive it. During an interview on 4/24/2024 at 8:05 AM, the DM said he had been employed at the facility for 8 years. He said nursing staff sent him diet orders and then he entered the orders into the dietary system. He said the kitchen staff followed the orders that were printed on the tray card tickets. He said Resident #15 was entered into the dietary system for double portions this morning and prior to today, he was not on double portions according to the tray cards. He said the last diet order for Resident #15 that he received was on 2/5/2024 with a change to full liquid and prior to that diet order on 4/7/2023, there was an order to change to a pureed diet. He said Resident #15 did have an order for double portions in the charting system but was not sure why it only showed a regular diet, pureed, and did not include the special instructions of double portions. He said double portions meant to place two scoops of everything on the tray. He said he was responsible for ensuring diet orders were followed through. He said residents could be at risk for weight loss or going to the hospital for a number of things. He said going forward he would ensure his staff followed what the ticket said and would get with ADON F to ensure orders matched. He said he had been meeting with ADON F weekly before to discuss weight loss and orders. Record review of a nursing-dietary communication form dated 2/5/2024 for Resident #15 indicated a readmission with a diet order of full liquid. Record review of a nursing-dietary communication form dated 4/7/2023 for Resident #15 indicated an order for pureed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/24/2024 at 9:30 AM, the DON and Administrator both said diet orders were the responsibility of the ADON's for ensuring diet changes were given to the dietary manager. They both said they were not aware until yesterday 4/23/2024 when the State Surveyor brought it to their attention about Resident #15 not having double portions on his lunch tray. Both said they would conduct random audits every 2 weeks to ensure orders were correct. Both said residents could be at risk for weight loss. Record review of a facility policy titled Diet Orders/Diet Manual undated indicated, .To ensure correct understanding and interpretation of therapeutic diets, all diets are ordered as stated in the diet manual. The physician will prescribe diets in accordance with the approved diet manual. A written order must appear on the medical record before the resident may be served. 3. Upon admission, nursing service transcribed the diet order as it is written by the physician on the diet order transmittal form. Forms are sent to dietary service prior to meal service .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46436 Based on observations, interviews, and record review the facility failed to ensure that residents who need respiratory care were provided such care, consistent with professional standards of practice for 1 of 9 residents (Resident #65) reviewed for oxygen usage. The facility failed to ensure Resident #65 had oxygen humidification when in use on 4/22/2024 and 4/23/2024. This deficient practice could place residents at risk of respiratory infections and irritation to nasal passages. The findings were: Record review of a facility face sheet dated 4/23/2024 indicated Resident # 65 was a [AGE] year-old male that admitted to the facility on [DATE] with a diagnosis of fluid overload. Record review of a comprehensive care plan dated 02/15/2024 indicated Resident # 65 required oxygen therapy, monitor for signs and symptoms of respiratory distress, and had a possibility of respiratory infections, and to administer oxygen as ordered. Record review of a quarterly MDS assessment dated [DATE] indicated Resident # 65 had a BIMS score of 14 indicating intact cognition, had shortness of breath, and required oxygen therapy. Record review of a consolidated physician order summary report dated 4/23/2024 indicated an order from 01/27/2023 for oxygen at 5 liters per nasal cannula every shift. During an observation on 4/22/2024 at 9:12 am Resident # 65 had oxygen in place at 5 liters per nasal cannula and the prefilled humidifier bottle was empty and not dated. During an observation and interview on 4/23/2024 at 8:11 am Resident # 65 was in the bed with oxygen in place at 5 liters per nasal cannula. The prefilled humidifier bottle was empty and not dated. Resident #65 stated the staff changed it a few days ago but could not remember when. He said when there was no water in the bottle his nose would get very dry, and it was uncomfortable. During an interview on 4/23/2024 at 8:17 am LVN C said she had worked at the facility for 3 years. She said Resident #65 was on a high flow of oxygen and should have water humidification. She said the bottle of water was changed frequently because of his high flow liters but was not aware that the humidifier bottle was empty. She said the bottle should be dated as well. She said that the resident could have infections or nasal dryness if the humidifier bottle was not changed appropriately. During an interview on 4/24/2024 at 8:33 am the ADON said she was responsible for competency checks for the nurses and aides. She said that the nurses were to check their oxygen setup with rounds to ensure the oxygen was working properly and to check the humidification system. She stated if the resident was on high flow oxygen, he should have humidified oxygen to prevent nasal dryness and irritation. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/24/2024 at 9:53 am the DON said the nursing administration was responsible for oversight of the nursing staff for oxygen administration. She said the nurses were trained to check resident oxygen setup with rounds and should ensure the humidification system had water if the resident was on a high flow of oxygen. She said if oxygen was not humidified it could cause dryness of the nares and thickened secretions. She said that she expected all nurses to check each residents oxygen and change the humidification system as needed. During an interview on 4/24/2024 at 10:04 am the Administrator said that oxygen training was the responsibility of the nursing administration. He said he expected all staff to follow the facility's policy for oxygen delivery to prevent resident discomfort. Record review of a facility policy titled Oxygen Administration dated February 13, 2007, indicated, .all sources require humidification to prevent drying of mucous membranes and thickening of respiratory secretions if used routinely. 5. Assemble the concentrator: fill the humidifier container, note the water in the humidifier is bubbling .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40124 46436 Based on observations, interviews, 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 2 of 4 staff (CNA A and CNA B) and 2 of 4 residents (Resident #13 and Resident #65) reviewed for infection control. CNA A did not change gloves or perform hand hygiene during incontinent care to Resident #13 on 4/22/2024. CNA A and CNA B did not change gloves or perform hand hygiene during incontinent care to Resident #65 on 4/22/2024. These failures could place residents at risk of exposure to communicable diseases and infections. The findings were: 1.Record review of a facility face sheet dated 04/23/2024 indicated Resident #13 was a [AGE] year-old female and admitted to the facility on [DATE] with a diagnosis of End Stage Renal Disease (inability of the kidneys to filter waste), diabetes (high glucose content in the blood), and morbid obesity. Record review of a quarterly MDS assessment dated [DATE] indicated Resident #13 had a BIMS score of 12 indicating cognition was mildly impaired and was incontinent of urine and bowel requiring total assistance with toileting. Record review of the care plan dated 02/14/2024 indicated Resident #13 had an ADL (activity of daily living) function disorder and to assist with ADLs as needed. During an observation and interview on 04/22/2024 at 9:43 am Resident # 13 was provided incontinent care by CNA H and CNA A. Both CNA's donned (applied) gloves. CNA H positioned Resident # 13 and held her on her right side while CNA A provided incontinent care to Resident # 13's front genitalia using wipes to clean across the peri area. CNA A discarded the wipe with a large amount of feces, changed gloves but did not sanitize. CNA donned gloves, wiped down the right side, discarded the wipe and gloves with a large amount of fecal material. CNA A applied clean gloves but did not sanitize. CNA donned gloves, wiped down the left side, discarded the wipe and gloves with a large amount of fecal material. CNA A applied clean gloves but did not sanitize. CNA A wiped the buttocks of Resident #13 with a wet wipe, discarded the wipe then took her gloved hand and pushed debris off bed linens with same gloves that had removed the BM. CNA A said she should have sanitized after each glove change. She said she failed to use sanitizer because they didn't bring any into the room. CNA A said she had been a CNA for 2.5 years and had received training on incontinent care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of a facility face sheet dated 04/23/2024 indicated Resident # 65 was a [AGE] year-old male that admitted to the facility on [DATE] with the diagnosis of fluid overload. Record review of a quarterly MDS assessment dated [DATE] indicated Resident #65 had a BIMS score of 14 indicating intact cognition, was incontinent of bowel and bladder and was dependent on staff for toileting. Record review of a comprehensive care plan dated 03/28/2024 indicated Resident # 65 had bowel and bladder incontinence and required assistance from staff for personal care. During an observation on 04/22/2024 at 9:13 am Resident # 65 was provided incontinent care by CNA B and CNA A. Both CNA's donned (applied) PPE and entered the room. Resident # 65's brief was opened by CNA B and perineal care was provided to Resident # 65's front genitalia using wipes. CNA A then assisted Resident # 65 to turn onto his left side and provided perineal care to his buttock's region using wipes. CNA A then removed the soiled brief and placed a clean brief under Resident # 65 without changing her gloves or performing hand hygiene. CNA A and CNA B proceeded to provided care wearing soiled gloves by obtaining clean clothing from Resident # 65's dresser, dressed Resident # 65, and then transferred Resident # 65 into his wheelchair. It was not until care was complete that both CNA A and CNA B removed their PPE and performed hand hygiene. During an interview on 04/22/2024 at 9:25 am CNA B said she had been a CNA for 1 year and said during incontinent care she should have changed her gloves from dirty to clean and she had received training on incontinent care. She said by not removing soiled gloves it could cause the spread of infections. During an interview on 04/22/2024 at 9:32 am CNA A said she had been a CNA for 2.5 years and had received training on incontinent care. She said during incontinent care she should have changed her gloves when going from dirty to clean. She said she should have removed her gloves, washed her hands, and put on new gloves before getting Resident # 65 dressed and transferred to prevent spread of infection. During an interview on 04/22/2024 at 12:00 pm the DON said she was very disappointed the CNA's did not follow the proper procedure for hand hygiene and they should have removed their gloves and used hand santizer or soap and water before applying new gloves . She said that not following correct hand hygiene could cause urinary tract infections. She said that she had just completed in-services for hand hygiene and peri care on 03/12/2024. During an interview on 04/23/2024 at 3:20 pm the Administrator stated infection control oversight was the responsibility of the DON. He stated if infection control measures were not followed it could cause infections and expected that infection control measures were followed. During an interview on 04/24/2024 at 8:33 am the ADON said she was responsible for competency checks for the nurses and aides. She said that CNA A and CNA B were both trained on proper incontinent care and hand washing. She said if proper technique was not followed it could cause infections. Record review of CNA proficiency audit dated 6/28/2023 indicated CNA B had been observed in perineal care and was competent in proper incontinent care technique. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of competencies for aide's checklist dated 4/05/2024 indicated CNA A had demonstrated competency for perineal care/incontinent care of male resident. Record review of an undated facility policy titled Hand Hygiene indicated, hand hygiene for the following, before and after assisting resident with personal care, after handling soiled material, after removing gloves . Record review of a facility policy titled Perineal Care dated 5/11/2022 indicated, .24) doff gloves and PPE and 25) perform hand hygiene .

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on observations, interviews, and record review, the facility failed to be equipped to allow residents to call for staff through a communication system which relays the call directly to a centralized staff work area for 1 of 10 residents (Resident #77) reviewed for call lights. The facility failed to ensure Resident #77's emergency call button in the bathroom had a pull cord. This failure could place residents at risk of injury, pain, and hospitalization . The findings included: Record review of a face sheet dated 4/23/2024 for Resident #77 indicated she was a 94-year female admitted [DATE] with diagnosis of CKD Stage 3 (moderate kidney damage), age related osteoporosis (brittle bones), and neuromuscular dysfunction of bladder (lack of bladder control). Record review of a quarterly MDS dated [DATE] for Resident #77 indicated she did not have any impairment in thinking with a BIMS score of 13. She required setup/clean up assistance with toileting. Record review of a care plan dated 2/12/2024 revised on 4/5/2024 for Resident #77 indicated she performed self in and out catheterizations (removing urine from the bladder by placing a tube into the bladder), has signed a NRA (negotiated risk agreement) understanding the risks involved with performing her own in/out catheterizations. Interventions included to educate the resident on risks. During an observation and interview on 4/22/2024 at 8:52 AM the bathroom call button in Resident #77's room did not have a pull string. The call button was attached to the wall in the bathroom by the grab bar. Resident #77 was in the room and said she had been at the facility since January 2024 and used her bathroom all the time. During an interview on 4/23/2024 at 3:42 PM, CNA G said she had been employed at the facility for 6 years and was assigned to the hall where Resident #77 resided. She said Resident #77 admitted to the facility not long ago and was independent. They would assist her to the shower but other things she could do on her own. She said she went to the bathroom on her own and they never had to go into the bathroom with her. During an observation and interview on 4/23/2024 at 11:10 AM in the bathroom of Resident #77, the Maintenance Supervisor said he had been employed at the facility for 2 months. He said he was responsible for checking the calls lights in all the rooms in the facility and checked them weekly on Mondays. He said he checked Resident #77's call lights, where Resident #77 resided on yesterday 4/22/2024 in the room and the bathroom, and they worked properly. When asked about the string for the call light in the bathroom, he said the string needed to be longer. He said he was unaware that the strings for the bathroom call lights needed to be close to the floor in the event a resident had a fall. He said a resident would be on the floor for a while if they had a fall and could not reach the string to call for help. He said he would add a string to the call light in the bathroom. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455959	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westward Trails Nursing and Rehabilitation	3001 Westward Dr Nacogdoches, TX 75964

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a Call light log for the month of April by the facility indicated Resident #77's room was checked on 4/22/2024, no issues noted. During an interview on 4/24/2024 at 9:30 AM, the DON and Administrator both said typically the call light strings were handled by maintenance and they should be long enough to reach the floor. They said when maintenance did the weekly checks, they would add to make sure the strings were long enough. They said if the call light strings in the bathrooms were not long enough, residents could fall and not be able to call for help. A copy of their policy on call lights was requested and was told the facility does not have a policy on call lights.

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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on observations, interviews, and record review, the facility failed to follow their own established smoking policy for 1 of 8 resident (Resident #62) reviewed for smoking. The facility failed to follow their policy on smoking when Resident #62 had smoking materials that included a lighter and cigarettes in his possession. These failures could place residents at risk of injury, burns, and an unsafe smoking environment. The findings included: Record review of a face sheet dated 4/22/2024 for Resident #62 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnosis of nicotine dependence, cigarettes, with withdrawal, atherosclerotic heart disease (clogged, blocked arteries), and peripheral vascular disease (decreased blood flow to the legs). Record review of a care plan dated 12/4/2023 for Resident #62 indicated he smoked with interventions for no smoking materials or igniter's to be stored in the resident's room. Record review of a safe smoking assessment dated [DATE] and 4/3/2024 for Resident #62 indicated he was deemed safe to smoke. Record review of a Discharge Return Anticipated MDS assessment dated [DATE] for Resident #62 indicated the brief interview for mental status was not evaluated. During an observation and interview on 4/22/2024 at 8:42 AM, Resident #62 was in his room in bed awake. He said he had been at the facility since December 2023. There were two lighters on his over bed table and a box of cigarettes. He said he was a smoker and he smoked after he ate, and staff were always with him when he went out to smoke. When asked if he could keep his smoking materials he did not answer. During an observation on 4/22/2024 at 12:34 PM, Resident #62 was pushed in his wheelchair from the dining room by staff after eating lunch to the outside area for a smoke break. One staff was present and told Resident #62 that he did not have a lighter. Resident #62 did not say anything and pulled out a cigarette and a lighter from his pocket and lit his cigarette. During an observation on 4/23/2024 at 9:50 AM, Resident #62 was in his room in bed and there was a lighter on his over bed table. During an interview on 4/23/2024 at 3:42 PM, CNA G said she had been employed for 6 years at the facility and was assigned to work the hall where Resident #62 resided. She said Resident #62 was a smoker and had not been at the facility long. She said they do not have anyone that can go out by themselves. She said she had seen him with cigarettes and lighter in his room a couple of times and they were taken from him. Resident #62 was fully aware that he was not supposed to have them. She said if residents kept their cigarettes and lighters, there could be a risk of a fire. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455959	A. Building B. Wing	04/24/2024

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/23/2024 at 3:52 PM, CNA H said she had been employed at the facility for 2 years and worked the hall where Resident #62 resided. She said Resident #62 was a smoker and different staff were assigned to take the residents who smoked outside. She said they have found smoking materials that included cigarettes and a lighter last week with him, and they gave the material to the nurse to be locked up at the nurse desk. She said residents could be a risk of fire if they kept their cigarettes and lighters. During an interview on 4/23/2024 at 3:59 PM, LVN J said she had been employed at the facility for 2 years and worked the hall where Resident #62 resided. She said Resident #62 was deemed a safe smoker and knew how to light his cigarettes, but his smoking materials were kept in the medication room. She said one staff took out the residents who smoked. She said when Resident #62 first admitted to the facility, he was keeping smoking materials in his room, and it was removed. She said she was not aware that he had smoking materials in his room this week during survey. She said safe smoking assessments were completed monthly. She said if residents were allowed to keep their smoking materials on them, there was a risk of setting the facility on fire, injuring themselves, or others. Record review of a list of safe smokers undated indicated that Resident #62 was listed as a safe smoker. During an interview on 4/24/2024 at 9:50 AM, the DON and Administrator both said resident smoking materials were to be stored in the medication room and any staff could take them out to smoke. Both said Resident #62 was deemed a safe smoker and he could smoke unsupervised, but that he was not allowed to have smoking materials in his room. Both said Resident #62 has had smoking items confiscated (taken) in the past and on yesterday 4/23/2024, he had a lighter in his pocket. The DON said they have educated Resident #62 about not being able to keep smoking materials with him all the time. The DON said staff were responsible to ensure smoking materials were put back up after the resident had finished smoking. Both said going forward they would educate staff on the facility smoking policy and said residents were at risk for injuring themselves or others and there was a risk of fire in the facility if residents kept their smoking materials. Record review of a facility policy titled Uniform Smoke Free Policy undated indicated, .Smoking tobacco, matches, lighters, or other smoking paraphernalia are not permitted to be kept or stored in a residents' room. A resident who is assessed safe to smoke unsupervised, will be instructed to obtain their smoking paraphernalia from a designated, secured area. The resident will be instructed to return the smoking paraphernalia following the smoking session .