STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555076	A. BUILDING _____ B. WING _____	**03/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVOCADO POST ACUTE	**510 E. WASHINGTON AVENUE EL CAJON, CA 92020**

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 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two staff (CNA 2 and LN 2) reported Resident 1's allegation of sexual abuse to the facility's administrator. As a result, the facility reported an allegation of rough handling during care, and did not report the allegation of sexual abuse to the State Survey Agency. This inaccurate reporting had the potential to put other residents at risk for sexual abuse. Findings: Resident 1 was readmitted to the facility on [DATE], per the facility's Resident Face Sheet. On 6/27/19 at 11:50 A.M., an interview was conducted with LN 2. LN 2 stated Resident 1 came to her on 6/19/19 between 8 A.M. and 10 A.M. and told her she did not like the way CNA 6 handled her during the cleaning of an incontinence episode (uncontrolled release of urine or feces). LN 2 stated Resident 1 asked her to speak to the DON about it. LN 2 stated Resident 1 told her CNA 6 had inserted his fingers into her anus. LN 2 stated Resident 1 referred to what CNA 6 had done as something that started with an s, a word she was not familiar with. LN 2 stated she did not report Resident 1's allegation against CNA 6 to the DON because she assumed the LN and charge nurse taking care of Resident 1 would have reported it. LN 2 stated she should have reported Resident 1's sexual allegation to the facility's administrator or DON. A review of Resident 1's Physician's Progress Notes, dated 6/24/19, indicated, .(Resident) seen in consult re:(regarding) accusation of staff inappropriate behavior. According to the pt (patient) - male LVN (licensed vocational nurse) came to clean her after she moved her bowels . -while cleaning her she felt pain in her rectum -she believes this pain was caused by him inserting his finger On 6/27/19 at 2:35 P.M., an interview was conducted with Resident 1. Resident 1 stated CNA 6 had changed her soiled brief and was real rough and put his fingers into her anus. Resident 1 stated she told LN 2 and CNA 2 about the incident. On 6/28/19 at 8:20 A.M., an interview was conducted with CNA 2. CNA 2 stated she took care of Resident 1 during the day shift on 6/19/19. CNA 2 stated she went in to see Resident 1 at the start of her shift and noticed the resident seemed different and was upset. CNA 2 stated Resident 1 told her she had a bad night last night. CNA 2 stated Resident 1 told her CNA 6 had been really rough during a brief change and had been digging in there. CNA 2 stated Resident 1 told her she felt sodomized (anal penetration/intercourse) by CNA 6. CNA 2 stated she did not know what sodomized meant and had to google it (look it up) when she got home. CNA 2 stated when a resident made an allegation of being sodomized, it would be considered sexual abuse. CNA 2 stated she should have come forward and told the ADM about Resident 1's sexual abuse allegation. CNA 2 stated she did not tell the ADM because she assumed everyone was aware of the sexual nature of the allegation. On 6/28/19 at 11:15 A.M., an interview was conducted with CNA 6. CNA 6 denied Resident 1's allegation. CNA 6 stated when he returned to work (on 6/23/19), he became aware Resident 1 accused him of sodomizing her from other staff on the night shift. CNA 6 stated he did not report the allegation against him to the administrator. On 6/28/19 at 12:10 P.M., an interview was conducted with the AA. The AA stated CNA 2 and LN 2 should have reported Resident 1's allegation of sexual abuse to the AA or administrator. The AA stated an allegation of sodomy was different from rough handling. The AA further stated when staff did not report Resident 1's sexual abuse allegation, it contributed to the facility's inaccurate reporting of the incident. The AA stated the facility should have notified the State Agency of Resident 1's sexual abuse allegation. The AA stated the manner in which Resident 1 was treated would have been different had the facility been aware of the sexual allegation. The AA stated had the facility been aware, Resident 1 would have been sent to the emergency room for a sexual assault exam and the police would have been called. On 7/16/19 at 9 A.M., an interview was conducted with the DON. The DON stated when Resident 1 told LN 2 and CNA 2 about feeling sodomized by a CNA, both staff should have reported the allegation to the ADM or DON. The DON stated all staff to whom the residents report an allegation of abuse to were required to report it to the ADM. The DON stated all staff were considered mandated reporters and were required to report all allegations of abuse. The DON stated there were mandated reporters in this case who did not report Resident 1's sexual abuse allegation. The DON stated this should not have happened. A review of the facility's undated employee training document titled, Abuse Reporting, 1. Who is the facility Abuse Coordinator? (name omitted), administrator . or designee (name omitted) Asst. (assistant) Administrator. 2. What to report? Suspected or witnessed abuse. 3. When to report? Immediately. 4. Report to: Abuse Coordinator or Designee, California Department of Public Health CDPH, Ombudsman, local law enforcement. 5. Who is a Mandated Reporter? All health employees, including nursing, dietary, housekeeping, laundry, rehab, maintenance
F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to thoroughly investigate an allegation of abuse as per the facility's Abuse Investigation and Reporting policy for one resident (Resident 1), when Resident 1 alleged CNA 6 anally penetrated her with his fingers during care. In addition, the facility failed to report the results of the facility's investigation to the State Survey Agency within 5 working days of the alleged incident. Failure to thoroughly investigate Resident 1's allegation of sexual abuse and to report the results of the facility's investigation to the State Survey Agency within 5 working days, had the potential to place Resident 1 and other vulnerable residents at increased risk of abuse. Findings: Resident 1 was readmitted to the facility on [DATE], per the facility's Resident Face Sheet. On 6/27/19 at 10:05 A.M., an interview was conducted with the facility's ADM. The ADM stated she investigated an incident of alleged rough handling that took place during Resident 1's incontinence (inability to control bowel or bladder) care and brief change (on 6/19/19). The ADM stated the allegation was against CNA 6 and had occurred during the night shift. The ADM stated CNA 6 had cleaned Resident 1 after an incontinence episode and he had put a cream called A & D ointment on the resident's anal area. The ADM stated Resident 1 did not allude to the incident being sexual, but that the resident's story seemed to evolve. A review of CNA 6's undated statement indicated, .When I removed her brief I saw that she had redness around her anus, and in between her butt cheeks. When I started to clean her (Resident 1) she said I was being too rough. I said that I was sorry for the discomfort, and I would try to be gentler . I said she had a BM (bowel movement) so I have to get her clean. She asked to put cream on her after I was done, and (I) obliged her request On 6/27/19 at 11:50 A.M., an interview was conducted with LN 2. LN 2 stated Resident 1 came to her on 6/19/19 between 8 A.M. and 10 A.M. and told her she did not like the way CNA 6 handled her during the cleaning of an incontinence episode. LN 2 stated Resident 1 asked her to speak to the DON about it. LN 2 stated Resident 1 told her CNA 6 had inserted his fingers into her anus. LN 2 stated Resident 1 referred to what CNA 6 had done as something that started with an s, a word she was not familiar with. LN 2 stated she did not report Resident 1's allegation against CNA 6 to the DON because she assumed the LN and charge nurse taking care of Resident 1 would have reported it. LN 2 stated she should have reported it. LN 2 further stated she was told to do a skin check for Resident 1 early that same morning. LN 2 stated there was a little redness from wearing the brief, but no rash or redness on the resident's anal area. LN 2 stated there was nothing abnormal down there. LN 2 further stated

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555076	A. BUILDING _____ B. WING _____	03/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVOCADO POST ACUTE	510 E. WASHINGTON AVENUE EL CAJON, CA 92020

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 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) CNAs could apply A&D ointment to a resident's dry areas like feet with the permission of the LN. LN 2 stated she had not heard of applying A&D on open areas, rashes, or on someone's anal area. LN 2 stated A&D was like a lubricant and she would not expect a CNA to apply it to a resident's perineal (area between the pubic symphysis and coccyx) or anal area. A review of Resident 1's Physician's Progress Notes, dated 6/24/19, indicated, .(Resident) seen in consult re:(regarding) accusation of staff inappropriate behavior. According to the pt (patient) - male LVN (licensed vocational nurse) came to clean her after she moved her bowels . -while cleaning her she felt pain in her rectum -she believes this pain was caused by him inserting his finger When asked why she didn't call for help (resident stated) -'I don't know.' On 6/27/19 at 12:25 P.M., an interview was conducted with MD 1. MD 1 stated he spoke to Resident 1 (on 6/24/19) related to the incident that occurred (6/19/19) with CNA 6. MD 1 stated Resident 1 was not known for making things up and he would consider the resident to be a reliable historian. MD 1 stated Resident 1 told him CNA 6 had put his finger into her anus while cleaning her, and that it caused pain. MD 1 stated Resident 1 told him the incident had occurred over a four-minute period. MD 1 stated Resident 1 was believable, but that it did not make sense the incident occurred over four minutes without the resident crying out for help. On 6/27/19 at 2:35 P.M., an interview was conducted with Resident 1. Resident 1 stated it was difficult to recall the exact date, but on one occasion, CNA 6 had changed her soiled brief and was real rough. Resident 1 stated CNA 6 had big fingers that he put into her anus. Resident 1 stated it hurt really bad and she had asked him to stop. Resident 1 stated CNA 6 did not stop and he continued by telling her he had to get her clean. Resident 1 stated it felt like the incident had gone on for five minutes. Resident 1 stated, I just went numb and was kinda (kind of) in a sort of shock and just shut down. Resident 1 further stated CNA 6 put an ointment on her perineal area and that he just focused on my anus while applying the ointment. Resident 1 stated the ointment felt greasy. Resident 1 stated, What he put there was not the usual stuff. Resident 1 stated she usually got a paste put there and what CNA 6 had put on her felt different. Resident 1 stated the actions of CNA 6 made her feel violated. Resident 1 stated she saw CNA 6 again after the incident, and I couldn't believe it. Resident 1 stated, I'm scared he will come and take care of me again. Resident 1 stated she did not want something like this to happen to someone else. Resident 1 further stated she had told LN 2 and CNA 2 that CNA 6 had sodomized (anal penetration/intercourse) her. A review of the physician's History and Physical dated 5/14/19 indicated Resident 1 had the capacity to understand and make decisions. A review of Resident 1's MDS assessment (an assessment tool) dated 6/5/19, indicated the resident scored 14 on the BIMS (a score of 13-15 indicated the resident was cognitively intact). The MDS further indicated Resident 1 required extensive assistance and the help of one staff for toileting. On 6/27/19 at 3:50 P.M., an interview was conducted with the facility's ADM. The ADM stated it was now clear there was a sexual aspect to Resident 1's allegation and she would re-suspend CNA 6 and notify the police. The ADM stated when Resident 1 asked CNA 6 to stop providing care he should have stopped. The ADM stated CNA 6 was reeducated related to that. The ADM stated the investigation would have been handled differently had she been aware of the sexual allegation. The ADM acknowledged the investigation into Resident 1's allegation should have been more thorough before allowing CNA 6 to return to duty (on 6/23/19). The ADM stated, We could have done better. A review of facility documents titled One on One Inservice, signed by CNA 6 on 6/21/19, indicated, .Employee will understand and adhere to rough handling policy On 6/28/19 at 8:20 A.M., an interview was conducted with CNA 2. CNA 2 stated she took care of Resident 1 during the day shift on 6/19/19. CNA 2 stated she went in to see Resident 1 at the start of her shift (around 7 A.M.) and noticed the resident seemed different and was upset. CNA 2 stated Resident 1 told her she had a bad night last night. CNA 2 stated Resident 1 told her CNA 6 had been really rough during a brief change and had been digging in there. CNA 2 stated Resident 1 told her she felt sodomized by CNA 6. CNA 2 stated she did not know what sodomized meant and had to google it (look it up) when she got home. CNA 2 stated when a resident made an allegation of being sodomized, it would be considered sexual abuse. CNA 2 stated she should have come forward and told the ADM about Resident 1's sexual abuse allegation. CNA 2 stated she did not tell the ADM because she had assumed everyone was aware of the sexual nature of the allegation. CNA 2 further stated it was the LN who applied ointments to a resident's perineal area or buttocks, not the CNA. CNA 2 stated Resident 1 would sometimes get a barrier paste applied to her perineal area by the LN, but never A & D ointment. CNA 6 stated A & D ointment did not belong on a resident's genital area. On 6/28/19 at 9:20 A.M., an interview was conducted with LN 3. LN 3 stated she was familiar with Resident 1. LN 3 stated Resident 1 had not accused any other staff member of inappropriate behavior prior to the incident with CNA 6. LN 3 stated Resident 1 would sometimes receive an incontinence guard paste on her perineal and buttock area. LN 3 further stated A & D ointment was to be applied to the extremities, not the groin, anal, or perineal area. LN 3 stated applying A & D ointment to the perineal or anal area would be weird. A review of Resident 1's physician's orders [REDACTED]. Resident 1 had an active order dated 5/14/19, to Apply A & D ointment to feet bilaterally qhs (bedtime) maintenance dry feet On 6/28/19 at 10:30 A.M., a joint interview and record review was conducted with the SSA. The SSA stated the SSA interviewed residents who made allegations against a staff or complained about the way they were treated. The SSA stated she tried to interview Resident 1 on 6/20/19 and the resident did not want to discuss what had allegedly happened with her. The SSA stated she had not documentation her attempted to speak with Resident 1 or that the resident refused. The SSA stated it was her job to interview the residents in CNA 6's section to see if there were any further complaints related to the care he provided. The SSA stated she did not verify which residents CNA 6 had actually provided care for. The SSA stated she should have. The SSA stated Resident 1's allegation should have been looked into more thoroughly. On 6/28/19 at 11:15 A.M., an interview was conducted with CNA 6. CNA 6 stated he took care of Resident 1 on 6/19/19 and had changed the resident's brief around 6 A.M. CNA 6 stated Resident 1 told him he was too rough, but never asked him to stop. CNA 6 stated Resident 1 asked him to put A & D ointment on her. CNA 6 stated LN 1 gave him a cup with A & D in it that was mixed with a barrier cream and he applied it to Resident 1. CNA 6 stated he when he applied the cream he avoided the vagina and anus entirely. CNA 6 further stated he had worked at another facility (Facility 2) approximately two years ago, wherein there had been a previous allegation against him. CNA 6 stated he was accused of offering a resident cigarettes in exchange for oral sex. CNA 6 stated what he was accused of had never happened. A review of CNA 6's employee file indicated he had not disclosed Facility 2 as a recent previous employer on the facility's hiring paperwork. On 6/28/19 at 12:10 P.M., an interview was conducted with the AA. The AA stated the facility's investigation of Resident 1's allegation against CNA 6 had not been thoroughly investigated, and it should have been. The AA stated not all staff relevant to the alleged incident had been interviewed before CNA 6 had been cleared to return back to work and provide patient care. The AA stated the SSA should have verified CNA 6's assignments when checking for and interviewing potentially affected residents. The AA stated when Resident 1 declined to be interviewed by the SSA, the SSD should have been notified. The AA stated the manner in which Resident 1 was treated would have been different had the facility been aware of the sexual allegation. The AA stated had the facility been aware, Resident 1 would have been sent to the emergency room for a sexual assault exam and the police would have been called. The AA further stated the facility had not sent a report of their investigation findings to the State Survey Agency within five working days. The AA stated this should have been done. On 7/16/19 at 5:25 A.M., an interview was conducted with CNA 1. CNA 1 stated she had not worked on the night of the alleged incident (6/19/19). CNA 1 stated she returned to work a couple days later and Resident 1 told her of the alleged incident with CNA 6. CNA 1 stated Resident 1 told her she had felt raped by CNA 6, and that CNA 6 had put his fingers in her anus. CNA 1 stated the first time she was interviewed by the facility related to Resident 1's allegation was about two weeks ago. CNA 1 further stated she was working the night when CNA 6 returned to work after being suspended and cleared by the facility (6/23/19). CNA 1 stated she told CNA 6 he could not be in Resident 1's section because the resident said he had sodomized her. CNA 1 stated, I got in report he (CNA 6) couldn't work with her (Resident 1) and he shouldn't be in the section, but he was. CNA 1 stated Resident 1 was visibly upset when she saw CNA 6 back in her residential section. CNA 1 stated LN 1, who was the night charge nurse, had not been aware of Resident 1's allegation or CNA 6's clearance and return to work. On 7/16/19 at 6:15 A.M., an interview was conducted with LN 1. LN 1 stated she had worked on the night of the alleged incident (6/19/19) and had been the nurse in charge. LN 1 stated the facility had not interviewed her related to Resident 1's allegation against CNA 6. LN 1 stated when CNA 6 had been cleared and returned to work (6/23/19), she as the nurse in charge, learned about it from a CNA and not management. LN 1 stated, I was blindsided. LN 1 further stated on the night of the alleged incident she did not give CNA 6 any ointment to apply to Resident 1 after her brief change. LN 1 stated CNA 6 also did not ask her for any ointment. LN 1 stated she would not mix A & D ointment and a barrier cream together. LN 1 stated that did not happen. On 7/16/19 at 7:25 A.M., an interview was conducted with Resident 1. Resident 1 stated the facility did not notify her of the outcome of their investigation into her allegation against CNA 6. Resident 1 stated she was not told what happened, or if CNA 6 continued to work at the facility and could still provide care. On 7/16/19 at 9 A.M., an interview was conducted with the DON. The DON stated, I think we could have done a more thorough

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555076	A. BUILDING _____ B. WING _____	**03/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVOCADO POST ACUTE	**510 E. WASHINGTON AVENUE EL CAJON, CA 92020**

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 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) investigation. The DON stated the staff on the night shift who worked with CNA 6 and those who were at work on 6/19/19 should have been interviewed related to the alleged incident involving CNA 6 and Resident 1. The DON stated all staff pertinent to Resident 1's allegation should have been interviewed before CNA 6 was cleared and allowed to return to work and to provide patient care. The DON stated there were staff aware of Resident 1's sexual allegation against CNA 6 on 6/19/19 who did not report it to the ADM. The DON stated Resident 1's sodomy allegation was present right away, and the resident's story did not evolve. The DON stated had the facility been aware of Resident 1's allegation of being sodomized sooner, the facility would have sent her to the emergency room for an evaluation and the police would have been called. The DON stated this would have been done to protect the resident. The DON stated A & D ointment was to be used on a person's extremities and should not be applied to the perineal area unless prescribed by the physician. The DON stated a CNA could apply A & D ointment on a resident, but they had to have the LN's permission first. The DON stated CNA 6 should not have applied A & D ointment to Resident 1's perineal or anal area. The DON further stated the facility had not provided the results of their investigation of Resident 1's allegation to the State Survey Agency within five working days. The DON stated this should have been done. Per the facility's policy titled Abuse Investigation and Reporting, revised December 2016, .All reports of resident abuse . shall be promptly reported . and thoroughly investigated by facility management. Findings of abuse investigations will also be reported . 6. The Administrator will inform the resident . of the status of the investigation and measures taken to protect the safety and privacy of the resident . 1. The individual conducting the investigation will, as a minimum: g. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; j. Review all events leading up to the alleged incident . 6. The Administrator, or his/her designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident
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** Based on observation, interview, and record review, the facility failed to ensure its smoking policy was followed when two of two residents (10 and 15) were smoking cigarettes outside of the designated smoking times and without staff supervision. In addition, Residents 10 and 15 had access to unsecured smoking materials. These failures had the potential to put Residents 10 and 15 at risk for burn injuries and the facility as a whole at risk for fire. Findings: Resident 10 was readmitted to the facility on [DATE], per the facility's Resident Face Sheet. Resident 15 was readmitted to the facility on [DATE], per the facility's Resident Face Sheet. On 7/16/19 at 5:02 A.M., an observation was conducted. An unsampled resident went out onto the smoking patio. The smoking patio had no lights on and was pitch black. There were no staff present on the smoking patio. Residents 10 and 15 were also out on the smoking patio and both residents were sitting in wheelchairs. Resident 15 was smoking a cigarette and Resident 10 had an unlit cigarette in his mouth. Resident 10 borrowed Resident 15's cigarette and used it to light the unlit cigarette in his mouth. At 5:10 A.M., Resident 15 took his cigarette and tried to extinguish it with his fingertips. Resident 15 could not extinguish it, and attempted to put out the cigarette on his pants. The cigarette went out and Resident 15 wheeled himself inside the facility. At 5:15 A.M., Resident 10 threw what was left of his lit cigarette onto the ground. No staff were present on the smoking patio. On 7/16/19 at 5:20 A.M., an interview was conducted with LN 1. LN 1 stated she would check the smoking patio to see if residents were still out there. On 7/16/19 at 5:25 A.M., an interview was conducted with CNA 1. CNA 1 stated residents were not allowed to smoke unsupervised as something could catch fire. CNA 1 stated she was aware there were regular residents who went out to smoke unsupervised. CNA 1 stated sometimes the nurse would have CNAs go check and see if anyone was smoking unsupervised. CNA 1 stated residents were not allowed to keep their own smoking materials, but some did anyway. On 7/16/19 at 6:15 A.M., an interview was conducted with LN 1. LN 1 stated residents were not allowed to go out and smoke without staff supervision. LN 1 stated there were no smoke breaks during the night shift. LN 1 stated residents were not allowed to keep their own smoking materials. LN 1 stated she asked the SSD to go outside and check the smoking patio, and the SSD confiscated the resident's cigarettes and lighter. LN 1 stated unsupervised smoking was dangerous as residents could burn themselves or start a fire. A review of the facility document titled Smoking Patio Resident List for July 2019, indicated the designated smoking times were between 6:30 A.M. to 10 P.M. On 7/16/19 at 8 A.M., an interview was conducted with the SSD. The SSD stated LN 1 asked her to go observe the smoking patio earlier. The SSD stated she smelled cigarette smoke, and confiscated cigarettes and a lighter from the residents on the smoking patio. The SSD stated residents were not supposed keep their own smoking materials. The SSD stated staff were supposed to keep the residents' smoking materials in a secured location. The SSD stated the smoking patio was supposed to be locked and off limits to residents during the night shift. The SSD further stated she witnessed Resident 10 access the smoking patio using the staff pencode to unlocked the door. The SSD stated, We need to change the code. A review of Resident 15's nursing notes dated 7/16/19 at 7:45 A.M., indicated, Received report that resident was seen putting out lit cigarette onto pants. Pants with visible site that appears to be burnt On 7/16/19 at 9 A.M., an interview was conducted with the DON. The DON stated there was no smoking on the night shift and the smoking patio should have remained locked until it was time for a designated smoke break. The DON stated a staff member was supposed to be present when residents' smoked to maintain safety. The DON stated this had not been done when Residents 10 and 15 were smoking unsupervised. The DON further stated residents' were not allowed to keep their own smoking materials. The DON stated facility staff were supposed to keep the smoking materials secured. The DON stated this did not happen when Residents 10 and 15 had their own cigarettes and lighters. Per the facility's policy titled Smoking Policy, revised 11/2018, Residents .who smoke, will be given the opportunity to continue smoking on a limited basis at designated times . All smoking materials will be secured by the activities department Resident must not carry ignition materials .No resident will be permitted to keep on his person or in his/her room any smoking materials, . A staff member . must be in attendance at all times when residents are smoking