STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115409	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Fort Oglethorpe	1067 Battlefield Parkway Fort Oglethorpe, GA 30742

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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on observations and staff and resident interviews, the facility failed to provide the right to communicate in their preferred language for one of three residents (R76) reviewed for communication. The deficient practice had the potential for R76 not to receive needed care and services. Findings include:Review of the facility's undated document titled Notice of Nondiscrimination revealed the name of company organization provides free aids and services to people with disabilities to communicate effectively with us, including: Qualified sign language interpreters; Written information in other formats (large print, audio, accessible electronic formats, other formats). The name of company Organization provides free language services to people whose primary language is not English, such as: Qualified interpreters; Information written in other languages.Review of the electronic medical record (EMR) revealed R76 was admitted with diagnoses including but not limited to bilateral primary osteoarthritis of knee-PDx (affecting both knees), adult failure to thrive, and depression.Further review of R76 EMR revealed that his preferred language was Spanish, Castilian.Review of the annual Minimum Data Set (MDS) assessment for R76 dated12/18/2025 documented a Brief Interview of Mental Status (BIMS) score of 13, indicating little or no cognitive decline.A review of the care plan revised on 12/29/2025 revealed Problem: R76 does not speak in the dominant language of the facility. Language: Spanish. He understands some English. Goal: Effective communication will be maintained with R76 through next review, Approach: Use simple phrases ask simple questions in English as needed. Encourage him to use (signs/gestures/sounds, flash cards, assistive device, etc.) when expressing himself. If a family member or friend is present that speaks/understands language, get permission to call them when needed and post names and phone numbers in front of chart. Provide language interpreter line, foreign language translation device, etc.) to enhance communication.An interview on 1/15/2026 at 10:20 am with Registered Nurse (RN) EE, she that she attempted to comprehend R76 by utilizing nonverbal cues, as her primary language was Filipino. RN EE explained R76 spoke Spanish and she made efforts to communicate in English.Interview on 1/15/2026 at 10:30 am with Certified Nursing Assistant (CNA) FF disclosed that R76 preferred language was Spanish; however, she requested R76 to communicate in English, without utilizing any other forms of communication.Interview on 1/15/2026 at 2:56 pm with R76 and Licensed Practical Nurse (LPN) CC revealed that he often struggled to understand R76 due to a language barrier, as he did not speak Spanish. LPN CC shared that the CNAs managed to squeeze a few phrases from R76. Subsequently, LPN CC sought assistance and returned with a postcard containing details for a language line, noting that he had never utilized it before. Interpreter GG facilitated the dialogue between R76 and LPN CC. R76 stated that he had never used the language line to communicate with the staff, emphasizing that he could not engage in a meaningful conversation; he merely attempted to comprehend the situation.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115409	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Fort Oglethorpe	1067 Battlefield Parkway Fort Oglethorpe, GA 30742

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and review of the facility's policy titled, HVAC (Heating, Ventilation, and Air Conditioning), PTAC (Packaged Terminal Air Conditioner Clean Air Filters, the facility failed to maintain a safe, clean, and homelike environment by not ensuring PTAC units were clean, intact, and free of debris, rust, and damage in two of 14 rooms (room [ROOM NUMBER] and room [ROOM NUMBER]) on the 200 Hall. The deficient practice had the potential to affect resident comfort, air quality, and environmental cleanliness.Findings include:Review of the facility policy titled, HVAC (PTAC): Clean Air Filters, documented under the section titled, Steps:1. Remove or open access cover.2. Remove air filter and inspect for cleanliness. If filter is dirty, either wash or replace depending on type of filter. If clean, reinstall filter.3. Re-install access cover.4. Clean grill on cover.5. Close and make sure it is secure.6. At a minimum, air filters are to be replaced or thoroughly cleaned depending on type of filter every three months.Observation on 1/13/2026 at 10:12 am and 1/15/2026 at 10:30 am in room [ROOM NUMBER] revealed the PTAC unit had a broken front grill, visible residue inside the PTAC unit, and the air filter was observed to be broken.Observation on 1/13/2026 at 10:58 am and 1/15/2026 at 10:32 am in room [ROOM NUMBER] revealed the PTAC unit contained debris and visible rust.Observation and interview on 1/15/2026 at 12:14 pm with the Maintenance Supervisor (MS) revealed that inspection of the PTAC unit in room [ROOM NUMBER] showed the front grill was broken and missing an approximately six-inch by four-inch piece of plastic. Inspection of the PTAC unit in room [ROOM NUMBER] revealed the main screen was rusty and clogged. The MS stated that PTAC units were serviced monthly and acknowledged the observed units were not in good condition.Interview on 1/15/2026 at 2:29 pm with the Administrator revealed that maintenance staff were responsible for the cleanliness and upkeep of PTAC units and that expectations were for the units to be routinely cleaned and maintained. The Administrator stated that failure to maintain PTAC units could negatively impact cleanliness.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115409	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Fort Oglethorpe	1067 Battlefield Parkway Fort Oglethorpe, GA 30742

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, resident and staff interviews, and review of the facility's policy titled, Documentation: Charting Activities of Daily Living (ADLs), the facility failed to adequately provide Activities of Daily Living related to bathing for three of 46 dependent sampled residents (R) (R21, R33, and R84). The deficient practice had the potential to cause discomfort and compromise personal hygiene.Findings include: Review of the facility policy titled Documentation: Charting Activities of Daily Living (ADLs) revised 2/18/2021 revealed under Policy Statement: It is required for Activities of Daily Living (ADL) care given by Certified Nursing Assistants (CNAs) and Nurses to be documented under Care Assist in patient's/resident's Electronic Healthcare Record (EHR). The policy further under ADL Documentation Tracking: The healthcare center will utilize a daily tracking in Care Assist or the CNA ADL Flow Sheet for each patient/resident which includes the ADLs as defined by the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Manual. The policy additionally stated under Procedure: 1. CNAs are required to enter documentation at the point of care.3. The nurse shall review the ADL documentation daily and should not accept any documentation that is not legible. 1. Review of the electronic health record (EHR) revealed R21 was admitted to the facility with diagnoses including, but not limited to, hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, morbid obesity, type two diabetes mellitus, congestive heart failure, muscle weakness, difficulty walking, and abnormal posture. Review of R21's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented in Section C (Cognitive Patterns) a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Section GG (Functional Abilities and Goals) documented R21 required substantial to maximal assistance with showering/bathing, toileting, upper and lower body dressing, and personal hygiene, and was dependent on putting on and taking off footwear. Review of R21's care plan revealed the resident was care planned for potential ADL decline related to cerebrovascular accident, diabetes mellitus, hypertension, hyperlipidemia, congestive heart failure, and obesity. The care plan goal stated R21's ADL needs would be met and independence maximized within disease limitations. Interventions included showering or bathing on scheduled days and as needed and providing daily hygiene care. Review of R21's bathing sheets from 12/23/2025 through 1/13/2026 revealed bathing was documented on eight dates during the reviewed period. Documentation reflected a partial bed bath on 12/15/2025, 12/18/2025, and 12/29/2025; a complete bed bath on 12/16/2025 and 12/21/2025; and showers on 12/24/2025, 12/30/2025, and 1/6/2026. Review of the bathing documentation revealed R21 was scheduled to receive showers three times per week, however received fewer showers or bed baths than scheduled during the reviewed period. The bathing documentation did not reflect documentation indicating R21 refused showers or bed baths during the reviewed period. Review of progress notes dated 12/1/2025 through 1/15/2026 revealed documentation related to physician rounds, pharmacy recommendations, social services, and activities participation. Review of the progress notes during this period did not reveal documentation indicating R21 refused showers or bed baths, nor did the notes reflect attempts to re-approach the resident following refusal. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115409	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Fort Oglethorpe	1067 Battlefield Parkway Fort Oglethorpe, GA 30742

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 1/13/2026 at 10:58 am revealed R21 stated she was supposed to receive showers three times per week and reported she had not yet received a shower that week. Interview on 1/15/2026 at 10:32 am with R21 revealed she reported receiving showers only once per week despite being scheduled for showers on Tuesdays, Thursdays, and Saturdays. R21 stated she had never refused showers and expressed a desire to receive showers or bed baths three times per week as scheduled. Interview on 1/15/2026 at 10:36 am with CNA AA revealed she was aware of R21's scheduled shower days and stated CNAs were responsible for providing showers and documenting refusals when applicable. CNA AA stated residents typically received showers three times per week and that refusals were to be documented after multiple attempts. CNA AA stated, to her knowledge, R21 typically received showers three times per week and had not refused showers. Interview on 1/15/2026 at 10:43 am with CNA BB revealed residents generally receive showers three times per week and that each CAN was responsible for providing showers to assigned residents. CNA BB stated if a resident refused a shower, staff were expected to re-approach and notify nursing staff, with documentation required. CNA BB stated she was not aware R21 had been receiving minimal showers and stated R21 had not refused showers when she provided care. Interview on 1/15/2026 at 11:30 am with a Licensed Practical Nurse (LPN) CC revealed residents were typically scheduled to receive three showers per week and as needed. He stated if a resident refused a shower, staff were expected to ask the resident two to three times, and if the resident continued to refuse, staff were expected to document the refusal in the progress notes. LPN CC stated some residents refused showers, but not all residents, as many preferred to take showers. LPN CC confirmed R21's shower schedule was Tuesdays, Thursdays, and Saturdays. He stated R21 does not consistently receive her showers or bed baths. He stated, to his knowledge, R21 does not refuse showers. During the interview, the LPN reviewed the shower sheets and stated R21 had not received showers three times per week. He stated that after reviewing the shower sheets, it appeared that R21 had not been asked to take showers consistently. LPN CC stated his expectations for CNAs were to ensure shower sheets were completed accurately and that residents received their scheduled showers. He stated he should be verifying the shower sheets and ensuring showers were being provided, but he trusted that showers were being given as documented. LPN CC stated he would be verifying showers moving forward. He stated that potential negative outcomes for residents not receiving showers could include urinary tract infections, skin breakdown, skin infections, and other complications. Interview on 1/15/2026 at 11:49 am with the LPN Unit Manager DD revealed she described the typical protocol for residents who refused showers as the CNAs notifying the nurse, followed by the nurse re-approaching the resident. If the residents continued to refuse, staff were expected to document the refusal in the progress notes. LPN DD confirmed R21's shower schedule was Tuesdays, Thursdays, and Saturdays and as needed. She stated that while R21 may refuse showers on some days, she normally did not refuse. LPN DD reviewed the shower sheets and confirmed that during the prior month, R21 had received only eight showers or bed baths. She stated that the reason R21 received only eight showers or bed baths during the reviewed period was related to issues with showers or staffing. She confirmed that if residents refused showers, the refusal must be documented. The surveyor informed the Unit Manager that review of the progress notes for the prior month did not reveal documentation of shower refusals. The Unit Manager stated that if it was not documented, it means it was not done. LPN DD stated her expectations were that CNAs provide showers as scheduled and document care provided. She stated she was responsible for verifying that CNAs were giving residents their showers; however, she (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115409	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Fort Oglethorpe	1067 Battlefield Parkway Fort Oglethorpe, GA 30742

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	acknowledged she had not been verifying showers daily, stating she was unable to do so due to being busy. She stated her expectation was that CNAs take responsibility and accountability for the residents assigned to them. LPN DD stated potential negative outcomes for residents not receiving showers include skin issues, illness, and wounds. Interview conducted on 1/15/2026 at 12:02 pm with the Administrator confirmed expectations that nursing staff verify residents receive scheduled showers and that refusals were to be documented. The Administrator stated failure to ensure residents receive showers could place residents at risk for skin issues and odor. 2. A review of the EHR revealed R33 was with diagnoses including, but not limited to, peripheral vascular disease, unspecified, other abnormalities of gait and mobility, acquired absence of left leg below knee, other acute osteomyelitis, left ankle and foot-resolved with LBKA (left below the knee amputation), phantom limb syndrome with pain, legal blindness, as defined in USA, need for assistance with personal care. Review of R33's MDS assessment dated [DATE] documented in Section C (Cognitive Patterns) a BIMS score of 15, indicating the resident was cognitively intact. Review of R33's Care Plan revealed the Problem: R33 has experience an ADL Decline related to recent LLE (left lower extremity) Amputation. She currently uses a slide board for transfers with therapy and has been offered use of a total lift with 2 staff assistance for transfers if she is unable to bear weight on her R (right) leg. Goal: R33 will Improve ADL function to maintain independence through next review. Interventions Provide showers/bath on scheduled days and as needed. Review of R33's bathing sheets from 12/14/2025 through 1/15/2026 revealed bathing was documented on 14 dates during the reviewed period. Documentation reflected six out of 14 baths were received. Review of the bathing documentation revealed R33 was scheduled to receive showers three times per week, however received fewer showers or bed baths than scheduled during the reviewed period. The bathing documentation did reflect documentation indicating R33 refused on 12/18/2025 due water too cold this morning. During interview on 1/15/2026 at 11:38 am with LPN DD, she reviewed R33's point of care (documentation system) history for bathing and confirmed R33 did not receive scheduled bathing. LPN DD explained if it was not charted it is not done. Observation and interview on 1/15/2026 at 11:59 am with R33 revealed that she was not refusing to bathe; rather, the staff was simply lazy. R33 confirmed she desired them (baths). R33 was observed lying in bed disheveled. 3. Review of the EHR revealed R84 was admitted to the with diagnoses including, but not limited to, unspecified dementia, white matter disease, unspecified, other abnormalities of gait and mobility, need for assistance with personal care, presence of right artificial hip joint, presence of left artificial hip joint. Review of R84's MDS assessment dated [DATE] documented in Section C (Cognitive Patterns) a BIMS score of 99, indicating the resident was severely impaired. Review of R84's Care Plan revealed the Problem: R84 is at risk for ADL Decline related to impaired (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115409	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Fort Oglethorpe	1067 Battlefield Parkway Fort Oglethorpe, GA 30742

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mobility, Dx (diagnosis) dementia with confusion. Goal: R84's ADL needs will be met and independence potential maximized within constraints of disease through next review. Interventions: Provide showers per schedule. Set up R84 for ADLs. Review of R84's bathing sheets from 12/14/2025 through 1/15/2026 revealed bathing was documented on 14 dates during the reviewed period. Documentation reflected five out of 14 bathing were received. Review of the bathing documentation revealed R84 was scheduled to receive showers three times per week, however received fewer showers or bed baths than scheduled during the reviewed period. The bathing documentation did reflect documentation indicating R84 refused on 1/14/2026. Interview on 1/13/2026 at 1:24 pm with Family Representative HH, who emphasized that she had requested the staff, three or four times over a two-week period, to wash the hair of R84 during bathing. Observation and interview on 1/15/2026 at 10:30 am with Certified CNA FF. CNA FF explained that ADL's include washing hair, shaving, bathing the body, and cutting nails. Observation of R84 was found lying in bed, and CNA FF confirmed that R84 hair seemed greasy. Interview on 1/15/2026 at 4:13 pm with the Administrator who confirmed that everyone should be receiving showers. There were no excuses.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115409	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Fort Oglethorpe	1067 Battlefield Parkway Fort Oglethorpe, GA 30742

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observations, staff interviews, and review of the facility's policy titled, Smoke Free Policy, the facility failed to adhere to the smoking times and to provide supervision during smoking for one resident (R) (R80) who was grandfathered in.Findings include:Review of the facility policy titled Smoke Free Policy revised 10/15/2019 revealed in section Procedure, .10. When the grandfathered patient/resident is identified as needing supervision, the supervision shall be provided by a partner who is physically present in the designated smoking area for all residents who need supervision based on their Smoking Observation Form or electronic documentation.Review of R80's electronic health record (EHR) revealed that he was admitted to the facility with diagnoses including, but not limited to, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side-pdx. unspecified lack of coordination, essential (primary) hypertension, vascular dementia, age-related nuclear cataract, bilateral.Further review of R80's EHR revealed his smoking status: current every day smoker.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R80 with a BIMS score of 12, indicating moderately cognitively impairment. Review of the care plan revised on 12/29/2025 revealed Problem: R80 is a supervised smoker. He is at risk for smoking related injury. Goal: R80 will not receive an injury R/T (related to) smoking through next review. Approach: provide staff supervision with smoking. R80 may smoke in designated areas at designated times with supervision.A review of physician's order dated 1/13/2026 for R80 revealed that R80 had been grandfathered in as a daily smoker.Review of the Smoking Observation Form dated 9/1/2020 revealed R80 was a Supervised Smoker.Review of the smoking times revealed designated smoking times were 9:30 am, 11:30 am, 2:00 pm, 4:30 pm, 7:15 pm, and 9:00 pm.Review of the CNA (Certified Nursing Assistant) Assignment Sheets were provided for dates 12/22/2025, 12/23/2025, 12/30/2025, and 1/15/2026 located at the nurse station revealed no medical staff was assigned for smoke breaks. Interview on 1/14/2026 at 2:13 pm with Registered Nurse (RN) II to verify the designated staff for the R80's smoke breaks, RN II examined the schedule and confirmed that no personnel had been assigned, noting that there was only one CNA on the 100 hall.Interview and Observation on 1/14/2026 at 2:15 pm with R80 and RN II, R80 observed in his room sitting on the edge of his bed, dressed. RN II asked R80 if he wanted to smoke; R80 shared he went to lobby area and waited for someone to go out, but no one showed, so he came back to his room.Observation and interview on 1/15/2026 at 9:22 am revealed R80 standing in the lobby area, waiting for a medical staff member to oversee his scheduled smoke break at 9:30 am. After no one arrived, R80 asked the surveyor for assistance and subsequently began to return to his room.Interview on 1/15/2026 at 9:36 am with Licensed Practical Nurse (LPN) DD, who disclosed that no individual was designated for R80's smoke break. LPN DD indicated that they were currently undergoing training with the scheduler; however, she typically oversaw the assignment of the smoke break, although she was presently engaged in delegating responsibilities. LPN DD provided updated CNA Assignment Sheet Days with smoking breaks allocated. Interview on 1/15/2026 at 10:30 am with CNA FF from the 100-hall disclosed that any staff member who was available may take residents outside for smoking. CNA FF mentioned that there used to be a book at the nurse station, not certain if the book is still present, but we used to be previously assigned.Interview on 1/15/2026 at 10:41 am with R80 disclosed that he frequently missed his smoke breaks.A phone interview on 1/15/2026 at 12:17 pm with the Staffing Coordinator (SC) confirmed that she did not designate a medical staff member for the smoke breaks; typically, it was the CNA assigned to the100 hall who managed this responsibility.