STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275159	A. Building B. Wing	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beartooth Rehabilitation and Nursing LLC	350 W Pike Ave Columbus, MT 59019

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview, and record review, the facility failed to protect residents from inappropriate physical contact between residents for 3 (#s 17, 28, and 37), failed to ensure a resident was free from verbal abuse by a staff member for 1 (#42) and failed to ensure a resident was free from neglect related to elopements for 1 (#46) of 7 residents sampled for abuse. With each elopement, the facility neglected to address it thoroughly for future prevention, thus continuing the risk of elopement and harm. Findings include:1. Review of a facility-reported incident submitted to the State Survey Agency on 1/3/26 showed documentation of inappropriate physical contact between resident #17 and resident #28. During an observation and interview on 2/7/26 at 1:15 p.m., resident #17 was in a wheelchair in his room and called out, Hey! On approach, he reached out and cupped the surveyor's hand with both his hands. Resident #17 was able to say Hey, Yeah, and No, throughout the interview. When asked about the incident on 1/3/26, resident #17 said. Yeah, and showed his fists to demonstrate punching, and then demonstrated pushing away of hands. When asked if he had any further contact with the individual involved in that event, and he said, No! During an interview on 2/7/26 at 2:22 p.m., resident #28 stated, Yeah, that guy groped at me. I pushed him away. He isn't right, but I am not going to let him get away with that! . I haven't seen him since. During an interview on 2/8/26 at 3:25 p.m., staff member A stated resident #17 has some history with (personal space and body) boundaries and stated, I told him he can't touch people and taught him to fist-bump because he especially likes to touch the ladies. Once he starts touching, that is when things escalate for him. None of the residents (involved in the events) could recall any incident, so we did not substantiate the abuse. I have told the staff not to write sexual behaviors in the (resident's) chart and just call them behaviors. Review of resident #17's SBAR note dated 1/3/26 showed, Notified by a resident that (Resident #17) inappropriately touched her bottom . Resident continually seeks out females attempting to touch or kiss. Has been seen groping (him)self while looking into female residents' rooms . [sic] Review of resident #17's care plan failed to show documentation specific to sexual behaviors or lack of physical boundaries with females, and there were no interventions addressing the risk for ongoing inappropriate physical contact with females before or after the 1/3/26 incident. The lack of interventions to address the sexual behaviors did not allow staff the opportunity to intervene appropriately when the resident was exhibiting the sexual behaviors. (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's investigation of the 1/3/26 incident showed, Attempted interview on 1/05/2026. [Resident #28] could not recall the incident on Saturday attempted interview on 1/05/2026 [Resident #17] could not remember what happened Saturday . Staff spoke with [Resident #17] about keeping his hands to himself and to not touch . [Resident #17's last name] has a BIMS of 3 & [Resident #28's last name] has a BIMS of 0 Neither resident could recall an incident unable to substantiate . [sic] A BIMS score of 0 or 3 reflects severe cognitive impairment. The facility failed to identify potential abusive behaviors and anticipate resident #17's behavior or needs, and failed to implement appropriate interventions to protect other residents or resident #17. 2. Review of a facility-reported incident submitted to the State Survey Agency on 1/25/26 showed documentation of inappropriate physical contact between resident #17 and resident #37. During an interview on 2/7/26 at 4:04 p.m., resident #37 could not recall any conflicts or incidents with another resident. During an interview on 2/9/26 at 3:12 p.m., staff member B stated, He (#17) bumped her (#37) thigh, and she got mad; that's all. Review of resident #17's SBAR note dated 1/25/26 showed, Resident has had increased sexual behaviors. Is there anything we could give him? . Review of resident #17's primary care physician progress note, dated 1/27/26, showed, Staff does note that he seems to be a little disruptive with his behaviors, some of them being somewhat sexual. Review of resident #17's care plan failed to show documentation specific to sexual behaviors toward resident #37 or protective measures implemented, before or after the 1/25/26 incident. Review of the facility's investigation of the 1/25/26 incident showed, Interview attempted on 1/25/2026 when admin got to facility [Resident #37] when asked can you tell me what happened in the dining room she said nothing happened [Resident #17's last name] interviewed and could not recall . Residents where separated, [Resident #17] was talked to by admin to keep his hands to himself. SBAR sent to the provider for medication review. Referral made to [mental health provider] . unable to substantiate. [sic] The facility did not show how the resident's cognitive impairments hindered his ability to understand discussions or any education related to the sexual behaviors. Review of a facility policy titled Abuse, Neglect and Exploitation, dated 4/11/25, showed, . 'Sexual Abuse' is non-consensual sexual contact of any type with a resident. The facility failed to substantiate sexual abuse for the residents involved, while simultaneously documenting #17's sexual behaviors and telling the resident to keep his hands to himself, without consideration of his cognitive impairments hindering his decisions, and staff failed to anticipate his needs. 3. Review of a facility-reported incident, dated 10/30/25 at approximately 6:30 a.m., documented an allegation during shift change wherein a staff member told resident #42, I wish you would shut the f k (profanity) up. Review of the facility's investigative report for the event on 10/30/25 showed the allegation was substantiated. Documentation further reflected that the facility conducted interviews with staff and (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents and concluded the statement was made to resident #42 as it was alleged. During an interview on 2/10/26 at 8:08 a.m., staff member D said she was aware of the incident regarding verbal abuse involving resident #42, and stated concerns had been raised regarding the staff member involved and interactions with other residents. During an interview on 2/10/26 at 11:34 a.m., staff member A stated the allegation (for resident #42) was received through a grievance and was reported to the State Survey Agency. Staff member A affirmed that the statement was made. Staff member A further stated that interviews conducted during the investigation identified additional reports describing the alleged staff member as rude and making residents feel small. Staff member A said the staff member's employment was terminated following the substantiated findings. The facility substantiated that the staff member directed profane and demeaning language toward resident #42. The use of such language was identified as verbal abuse, and facility failed to ensure resident #42 was free from abuse. 4. Review of a facility-reported incidents, dated 10/24/25, 11/1/25 at 10:20, 11/1/25 at 5:40 p.m., 12/3/25, and 12/6/25 showed resident #46 had left the facility five times in 43 days. During all five of resident #46's elopements, the facility was not aware she was missing. Resident #46 was found in the community, showing that the facility neglected to put effective plans in place to prevent further elopements. During one elopement, the resident was found approximately one mile away at a busy stop near the interstate. During an interview on 2/7/26 at 4:10 p.m., staff member J said Resident #46 was admitted to the facility after being discharged by a sister facility. Staff member J said resident #46 left the sister facility to go to a park where she would exchange sex for drugs. Staff member J said resident #46 had a history of being exploited for sex and drugs. Review of the facility's policy titled, Abuse, Neglect and Exploitation, implemented on 4/11/25, showed, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. [sic]

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report investigative findings for reportable events within the required timeframe for 4 (#s 27, 28, 37, and 46) of 8 residents sampled for event reporting. The failure placed the residents at elevated risk for delayed protective interventions, emotional distress, and injuries. Findings include: A review of facility reported incidents showed concerns related to late reporting, which included: 1. Resident #27 Review of a facility-reported incident submitted to the State Survey Agency on 10/2/25 showed resident #27 was mistreated by other residents in the dining room through verbal comments. The facility's investigative findings were not reported to the State Survey Agency until 10/10/25, one day after the submission deadline. 2. Resident #28 Review of a facility-reported incident submitted to the State Survey Agency on 1/3/26 showed resident #28 reported inappropriate touching by another resident. The facility's investigative findings were not reported to the State Survey Agency until 1/11/26, two days after the submission deadline. 3. Resident #37 Review of a facility-reported incident submitted to the State Survey Agency on 1/25/26 showed that resident #37 reported inappropriate and unwanted touching by another resident. The facility's investigative findings were not reported to the State Survey Agency until 1/31/26, one day after the submission deadline. 4. Resident #46 Review of a facility-reported incident submitted to the State Survey Agency on 11/1/25 showed an allegation of resident neglect when resident #46 eloped from the facility on 11/1/25 at 10:20 a.m. The facility's final investigation was submitted on 11/10/25, three days after the submission deadline. Review of a facility-reported incident submitted to the State Survey Agency on 11/1/25 showed an allegation of resident neglect when resident #46 eloped from the facility on 11/1/25 at 5:40 p.m. The facility's final investigation was submitted on 11/10/25, three days after the submission deadline. Review of a facility-reported incident submitted to the State Survey Agency on 12/3/25 showed an allegation of resident neglect when resident #46 eloped from the facility on 12/3/25. The facility's final investigation was submitted on 12/11/25, one day after the submission deadline. During an interview on 2/8/26 at 2:12 p.m., staff member A stated she was responsible for submitting reportable incidents, including the investigative findings. Staff member A stated she did not recall why the reports regarding residents #s 28 and 37 were submitted late. During an interview on 2/8/26 at 3:45 p.m., staff member B stated the three final investigation reports related to resident #46's elopements were submitted late. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/10/26 at 11:08 a.m., staff member A stated she did not submit the results of the investigation findings for the incident involving resident #27 within the five-day deadline because she had to work as the cook in the kitchen to cover the position when a staff member left abruptly. Review of a facility policy titled Abuse, Neglect, and Exploitation, dated 4/11/25, showed, VII B. The administrator will follow up with the government agencies during business hours, to confirm the initial report was received, and to report the results of the investigation when final within five working days of the incident, as required by state agencies. Review of a facility policy, titled Compliance with Reporting Allegations of Abuse/Neglect/Exploitation, revised 7/10/25, showed: .Procedure for Response and Reporting Allegations of Abuse/Neglect/Exploitation: 2. The Administrator or designee will: a. Notify the appropriate agencies immediately: as soon as possible, but no later than 2 hours after discovery of the incident or forming the suspicion. b. Obtain statements from direct care staff. . d. Follow up with appropriate agencies, during business hours, to confirm the report was received. . f. Within 5 working days of the incident, report sufficient information to describe the results of the investigation, and indicate any corrective actions taken, if the allegation was verified. [sic]

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to ensure a thorough investigation of facility-reported events for 1 (#46) of 8 residents sampled for facility-reported events. The failure placed the resident at risk for inadequate protection from harm. Findings include:Review of a facility reported incidents, dated 10/24/25, 11/1/25 at 10:20 a.m., 11/1/25 at 5:40 p.m., 12/3/25, and 12/6/25, showed resident #46 had left the facility premises without the facility knowledge. The investigative files presented for review failed to include a thorough investigation of one resident who had multiple elopements. No staff interviews were included in the files.During an interview on 2/7/26 at 4:10 p.m., staff member J said resident #46 had lived in a homeless shelter and was potentially in a witness protection program. Staff member J said the resident would be outside smoking unattended because the facility did not have the manpower to watch and supervise residents who smoked. Staff member J said the facility changed resident #46's activity care plan, but staff member J said she cannot remember what the resident needed to prevent further elopements.During an interview on 2/10/26 at 11:20 a.m., staff member H said she had never been interviewed regarding resident #46's elopement. Staff member H said she had some ideas why and how the resident eloped and had ideas for prevention, but she was not asked about what might prevent resident #46 from leaving the property again.During an interview on 2/10/26 at 11:50 a.m., staff member A said she did the investigation of the elopement. Staff member A said she could not interview staff because she just could not get it done and admitted a comprehensive review was not done. Staff member A said the facility found the resident had gone under the fence during one of the elopements, rather than over the fence as originally thought.Review of the facility reported incident dated 10/24/25 showed there was no investigative information and only copies of portions of the chart. The final report showed to prevent further elopement, the staff would be re-educated on elopement prevention procedures. The facility failed to provide documentation to show staff education was completed on or near 10/24/25. The facility presented a signed education roster, without documentation of the date, content of education, or the person presenting the education. Resident #46 eloped five more times within the next 43 days, while living at the facility. The facility provided files for the five investigations for resident #46's elopements. The investigations were incomplete and showed that the root causes of the elopements were not identified. No resident or staff interviews were included in the files to show the precipitating factors or timeline for resident #46 being missing. During all five of resident #46's elopements, the missing resident was identified by non-facility community members, showing that preventative measures were not effective, if implemented.Record review of a facility performance improvement plan, dated 12/8/25, showed the facility initiated a plan to prevent resident #46 from eloping. Audits showing when vendors were at the facility started on 12/8/25. Review of resident #46's nursing progress notes showed that resident #46 was discharged on 12/7/25.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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, interviews, and record reviews, the facility failed to implement and operationalize a smoking policy when there were smokers residing at the facility, who were unsafe and kept their smoking materials. Residents smoked in a designated and unmonitored smoking area; one resident (#12) utilized oxygen and kept her nasal cannula and oxygen cannister in close proximity while smoking, to include using a lighter with an open flame; resident (#20) was often in proximity to resident #12 when smoking, which placed her at a higher risk of injury due to the unsafe smoking practices of resident #12. The facility did not identify and address individualized smoking safety risk factors, and care plans were not implemented with individualized safety interventions to mitigate smoking-related risks for 6 (#s 5, 12, 20, 23, 24, and 35); and failed to ensure a lighter was secured in accordance with the resident's smoking assessment and care plan for 1 (#5) of 6 residents sampled for smoking. These failures increased the risk of harm for residents who smoked, as well as others in the facility. The concerns related to unsafe smoking contributed to the Immediate Jeopardy situation announced during the survey (see below). Findings include: On 2/9/26 at 1:30 p.m., the facility Administrator and Director of Nursing were notified that an Immediate Jeopardy existed in the area of F689 - Accidents and Hazards, pertaining to resident #12, which was identified to be at the severity and scope of J. Upon removal of the immediacy, this was lowered to an E. The facility submitted an acceptable plan to remove the immediacy, and it was verified by the State Survey Agency that the facility removed the immediacy as of 2/9/26 at 6:15 p.m. Findings include: As part of the required entrance conference materials to be submitted to the State Survey Agency, it was found during the document review(s) that the facility failed to provide an accurate list of residents who smoked. The list provided only included five resident names, not six. It was found that the facility had six residents who smoked. The list provided did not include resident #35, although a smoking safety screen had been performed for resident #35 on 7/23/25, which was two days after his admission on [DATE]. Concerns related to residents who smoke include: 1. Resident #12 - identified to be involved in the immediate jeopardy situation: During an observation on 2/7/26 at 2:14 p.m., resident #12's door to her room was open, and she was sitting up on her bed. Resident #12 was holding crafting materials in her hands. Resident #12 was using a lighter, which had an open flame, to heat pieces of the craft materials together and there was an oxygen concentrator by the bed. Multiple storage boxes of crafting materials, fabric, and supplies were lined against a wall beside her bed. A faint smell of material burning was noticed directly outside the door to the resident's room. There was no visible sign on the door to her room to show the hazard related to oxygen equipment being present or in use in the room. The door did not have any signage displaying No smoking. During an observation on 2/8/26 at 3:15 p.m., resident #12 was seated in a wheelchair, wearing a nasal cannula, with a portable oxygen tank attached to the resident's wheelchair. Resident #12 was being pushed by resident #20 to go into the dining room. The doors to the dining room were closed because of a church group activity. Staff member J was standing near the dining room doors, and resident #20 asked her about going outside to smoke. Staff member J stated to residents #12 and #20 that they would have to go outside later, since the activity was going on. Resident #20 pushed resident #12 in her wheelchair down the hallway away from the dining room doors. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation and interview on 2/9/26 at 8:24 a.m., resident #12 was seated in the designated smoking area outside with resident #20. Resident #12 was sitting in a wheelchair, wearing a nasal cannula, and smoking a lit cigarette; there was an oxygen cannister on the back of the resident's wheelchair. Resident #20 was sitting near resident #12 in a chair, approximately six feet away, smoking a lit cigarette. Resident #12 stated her oxygen was not turned on. Resident #12 stated, I don't want to blow myself up, the oxygen is off, see, and reached to the back of her wheelchair to twist the oxygen wrench to turn the valve closed. Resident #12 removed the nasal cannula from below her nose and lowered it to her sternum, like she was wearing a necklace. Resident #12 stated, Here, I will do this just in case, and pulled the nasal cannula tubing from around her chest to lie behind the wheelchair near the portable oxygen tank. The portable oxygen tank was held in an oxygen cylinder holder attached to her wheelchair. The oxygen pressure regulator showed a pressure reading of 800 psi in the oxygen tank. During an interview on 2/9/26 at 8:46 a.m., staff member F stated it was not safe for resident #12 to go outside to the smoking area to smoke wearing a nasal cannula with a portable oxygen tank. Staff member F stated, I'm newer to this environment (long-term care), but I don't think it's safe to have lighters in rooms, especially residents with oxygen. During an observation and interview on 2/9/26 at 8:54 a.m., resident #12 entered the outside smoking area with resident #20. Resident #12 had her lighter and a cigarette in her hand, with a nasal cannula in place under her nose. Resident #12 sat in her wheelchair approximately four feet away from resident #20, who sat in a chair. Resident #12 stated she had turned her oxygen tank off, lifted the nasal cannula prongs up to her mouth, and sucked air in from it. Resident #12 stated she still had air left in her oxygen tank. Resident #12 stated she had been a paramedic, so she knew how important it was not to have oxygen on when she smoked. During an interview on 2/9/26 at 9:05 a.m., staff member A stated resident #12 had not been going outside to smoke until resident #20 started to invite resident #12 to join her to go outside to smoke. Staff member A stated that resident #12 knew not to wear her nasal cannula or use oxygen when she smoked. Staff member A stated she had started to make sure resident #12 did not go outside with oxygen on. Staff member A stated resident #12 was not to keep lighters in her room with her oxygen equipment. Review of resident #12's smoking safety screen assessment, dated 11/26/25, showed the facility determined resident #12 was safe to smoke without supervision. The assessment showed resident #12 did not use supplemental oxygen, so the resident was not assessed to safely remove and store oxygen prior to initiating the smoking activity. Review of a facility policy titled Resident Smoking, implemented 4/11/25, showed resident #12's written name and signature, with no date, to show when the smoking policy was explained to resident #12 by staff, or when resident #12 initially agreed to the smoking policy. 2. Resident #5: During an observation and interview on 2/7/26 at 1:56 p.m., resident #5 stated she was a smoker and reported she kept her own smoking supplies. The resident showed the surveyor cigarettes and a lighter stored in a pouch inside her bedside dresser drawer. The lighter was accessible to the resident. During an interview on 2/9/26 at 8:10 a.m., staff member J stated resident #5 had previously been (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	found with marijuana and had hidden it in her room or outside. Staff member J stated resident #5's room had been searched on prior occasions. Review of resident #5's electronic health record showed resident #5 was admitted to the facility on [DATE]. Review of the resident #5's progress notes showed multiple concerns related to marijuana use and smoking safety as follows: -12/14/25 at 4:53 a.m., nursing progress note, .self-propels own w/c out to smoking area with staff supervision. -12/17/25 at 10:00 a.m., social service progress note, .Resident Advocate and CNA went and spoke with resident about the marijuana. Resident denied having any more marijuana and understands the rules and regulations of the facility. Resident stated that she has ran out of it. Resident Advocate notified administrator and DON of the outcome and will continue to monitor the resident to make sure there is no more marijuana in resident's room or on resident. [sic] -12/18/25 at 3:24 p.m., social service progress note, .Local law enforcement called as resident has been found with marijuana on the premises and was asked for it 2 days ago, but resident denied having any. Other residents in the facility reported that resident was still smoking it outside of the facility. Local law enforcement came and search residents' room and belongings with approval from resident. There was no marijuana found. Law enforcement then explained to resident about the marijuana use cannot happen at the facility as it was against facility rules and regulations and against federal law which the facility has federal funding. [sic] -12/26/25 at 9:25 a.m., nursing progress note, Note Text: A concerned resident informed this nurse this morning that she observed [Resident #5] allegedly smoking illegal products outside this morning in addition to dropping what appeared to be Visine in her coffee. It was also reported to be by this concerned resident that staff approaching [Resident #5] outside began to question what she was doing and she lied about what she had in her possession. [sic] -12/26/25 at 9:33 a.m., behavior progress note, Note Text: At approximately 9 am Resident Advocate was informed by another resident that resident was outside in the smoking area in the corner getting ready to smoke marijuana. Resident advocate went out another door and saw resident loading a marijuana pipe. When confronted resident lied and stated it was a cigarette. Resident then came back in the building and resident advocate in front of nursing staff asked resident for the marijuana, her pipe, and gold tin that she keeps it in. Resident denied having it and stated that she is not smoking marijuana on the premises. Resident advocate explained to resident that using marijuana along with being on morphine is dangerous and that it should not be mixed. -1/1/26 at 9:52 a.m., nursing progress note, Note Text: Resident room had aroma of marijuana. -1/3/26 at 2:03 p.m., nursing progress note, Note Text: Notified by staff that resident had marijuana on bedside table. Not visualized by nurse. Hospice nurse in room. Review of resident #5's comprehensive care plan, last reviewed on 12/30/25, showed, . Focus: At risk for injury and complications related to smoking. Date Initiated 12/15/25 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Goal: Resident will smoke safely and in accordance with the smoking policy through the next review. Date Initiated 12/15/25 Interventions: If unsafe smoking practices are observed or if it is suspected that resident has violated the smoking policy, staff shall intervene immediately as needed for safety and notify administrative staff so appropriate follow up actions can be taken. Date Initiated 12/15/25 -Resident has been assessed and determined to have independent smoking privileges. Date Initiated 12/15/25 -Smoking materials (lighter) to be stored securely at the nurse's station. Date Initiated 1/20/26. The resident's comprehensive care plan did not include an intervention requiring the lighter to be secured at the nurse's station until 1/20/26, despite the documented marijuana-related concern on 12/17/25 and multiple subsequent allegations. Additionally, on 2/7/26, the lighter remained in the resident's room and accessible, contrary to the care plan intervention initiated on 1/20/26. Review of resident #5's Smoking Safety Screen with an effective date of 1/16/25 showed, .C. Smoking Determination: 1. Based on the assessment, the facility has made the following determination related to resident smoking privilege status: a. Safe to smoke without supervision . 2a.Resident to keep lighter locked up at nurses station. [sic] 3. Resident #20: During an observation and interview on 2/9/26 at 8:26 a.m., resident #20 was outside in the designated smoking area with resident #12. Resident #20 was wearing a smoking apron, holding a lit cigarette, and smoking it while seated in a chair approximately six feet away from resident #12. Resident #20 stated, I wouldn't let her hurt herself, when asked about resident #12 having a tank of oxygen on her wheelchair while wearing a nasal cannula. Resident #20 stated she and resident #12 both had their own lighters and could use them unsupervised. There was no visible signage showing that the outside area was a designated smoking area, and there was no signage with information related to no oxygen use in the smoking area. Review of resident #20's smoking safety screen assessment, dated 1/20/26, showed the facility determined resident #20 was safe to smoke without supervision. The facility implemented a smoking apron as an intervention to ensure safety with smoking activity, due to, a tremor that worsens at times, placing her at increased risk for burns. 4. Resident #23: Review of the list of residents who currently smoke, provided by the facility on 2/7/26, showed that resident #23 was a smoker. During an interview on 2/9/26 at 12:47 p.m., staff members D and F were present. Staff member D said resident #23 did not smoke. Staff member D said the staff removed vapes from her room. Staff (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275159	A. Building B. Wing	02/10/2026

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	member D said if anyone were going to bring her cigarettes or vapes, it would be her sister. During an interview on 2/9/26 at 3:30 p.m., staff member F said she had seen vapes fall from resident #23's person to the floor. Staff member F said the nurses have recently taken vapes away from her, and they keep getting added to the collection in the medication room. Review of resident #23's Minimum Data Set, dated [DATE], showed resident #23 did not smoke. Review of resident #23's care plan did not include smoking or the use of vapes. 5. Resident #24: During an observation and interview on 2/7/25, resident #24 said he did smoke, but was allowed to be independent with his smoking. Resident #24 said it was difficult to get through the door to the smoking area because the threshold was steep, but he managed. Resident #24 said he had no issues with smoking at the facility. No smoking paraphernalia was observed during this observation. Review of resident #24's medical record showed a resident smoking policy in his chart. The facility policy had resident #24's printed name, but no date. Review of resident #24's smoking safety screen nurses' notes dated 1/14/26 showed resident #24 was able to safely demonstrate how to maintain the electronic cigarette according to the manufacturer's guidelines, including charging, cleaning, and storing the electronic cigarette. During an interview on 2/9/26 at 12:47 p.m., staff member D said resident #24 was found with a vape on his heater. The vape was removed and put into the medication room. Resident #24 had not asked for the vape back, and he is only smoking cigarettes. 6. Resident #35: During an observation and interview on 2/7/26 at 2:07 p.m., resident #35 was seated on his bed, moving tobacco materials. Resident #35 stated he was going to go outside to smoke with resident #5, who was in his room in her wheelchair. Resident #35 pulled tobacco from a bag and used paper to roll a cigarette. Several lighters and more bags of tobacco material were on resident #35's dresser next to his bed. Resident #35 stated smoking times were flexible, and smokers outside were not supervised by staff. Resident #35 stated he went outside with other residents who smoked, and stated resident #20 had to wear a smoking apron because she had burned her clothes. Resident #35 stated he thought resident #20's smoking apron was a punishment, and resident #20 should not be forced to wear it. Review of a facility policy titled Resident Smoking, implemented 4/11/25, showed: It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and non-smoking residents. 1. Smoking is prohibited in all areas except the designated smoking area. A Designated Smoking Area sign will be prominently posted. 2. Safety measures for the designated smoking area will include, but not limited to: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	. d. Accessible fire extinguisher.e. Prohibition of oxygen use in the smoking area.f. Located 20 feet from exits in order to protect non-smoking residents from second-hand smoke. 8. Any resident who is deemed safe to smoke, with or without supervision, will be allowed to smoke in designated smoking areas (weather permitting), at designated times, and in accordance with their care plan . 12. If a resident or family does not abide by the smoking policy or care plan (e.g., smoking materials are provided directly to the resident, smoking in non-smoking areas, or does not wear protective gear), the plan of care may be revised to include additional safety measures 13. Smoking materials of residents requiring supervision with smoking will be maintained by nursing staff. Review of a facility policy titled, Oxygen Administration, implemented 4/11/25, showed: . 11. Staff shall monitor for complications associated with the use of oxygen and take precautions to prevent them. Possible risks and complications include, but are not limited to: a. Fire . Review of a facility policy titled Accidents and Supervision, implemented 4/11/25, showed: . 1. Identification of Hazards and Risks- the process through which the facility becomes aware of potential hazards in the resident environment and the risk of a resident having an avoidable accident. a. All identifying staff (e.g., professional, administrative, maintenance, etc.) are to be involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident.