STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455471	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Health & Rehabilitation	1600 Muchison Rd El Paso, TX 79902

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident's right to make choices regarding aspects of his daily life, including beverage preference, for 1 of 6 residents reviewed for resident rights (Resident #6). The facility failed to honor Resident #6's wishes by not providing him with the beverage of his choice.Findings included: Record review of Resident #6's admission Record, dated 05/24/2025, revealed an [AGE] year-old male admitted [DATE] and readmitted [DATE]. Record review of Resident #6's History and Physical, dated 05/27/2025, revealed diagnoses including vascular dementia (decline in thinking ability due to reduced blood flow to the brain), type 2 diabetes mellitus (chronic condition affecting blood sugar control), hypertension (high blood pressure), chronic systolic congestive heart failure (condition where the heart does not pump blood effectively), chronic obstructive pulmonary disease (long-term lung disease causing breathing difficulty), seizure disorder (episodes of abnormal electrical activity in the brain), and left-sided hemiparesis (weakness on one side of the body). Record review of Resident #6's quarterly MDS, dated [DATE], revealed a BIMS score of 10, indicating moderately impaired cognition. The MDS revealed under Section C, Cognitive Patterns, Resident #6's cognitive skills for daily decision-making were independent. Record review of Resident #6's Care Plan, dated 02/06/2026, revealed congestive heart failure (a condition where the heart does not pump blood effectively, causing fluid buildup), chronic obstructive pulmonary disease (a long-term lung disease that makes breathing difficult), seizure disorder (a condition causing episodes of abnormal electrical activity in the brain resulting in seizures), diabetes mellitus (a chronic condition affecting the body's ability to regulate blood sugar), vascular dementia (decline in thinking ability caused by reduced blood flow to the brain), hemiplegia (paralysis or severe weakness on one side of the body), and peripheral vascular disease (poor blood circulation to the limbs due to narrowed blood vessels). The care plan included no restriction related to soda, caffeine, or beverages. Record review of Resident #6's Psychological Services Progress Note , dated 02/05/2026 at 12:40 p.m., revealed the resident reported being denied a soda at midnight by a staff member who pointed her finger close to his face. During an observation and interview on 02/17/2026 at 12:40 p.m., Resident #6 was alert, seated in his room. Resident #6 stated he remembered a previous night he requested a soda from a female staff. He stated he did not know the name of the staff but that it was a female CNA. Resident #6 said the staff told him it was too late for a soda and she could give him water instead. Resident #6 stated he felt angry and told her he could make his own decisions and it was not her job to tell him what he could drink. Resident #6 stated the staff ignored him and walked away. He stated the incident had made him feel like the facility did not care about his preferences. During a telephone interview on 02/17/2026 at 1:20 p.m., Resident #6's relative stated his family installed video cameras in the resident's room. Resident #6's relative stated they reviewed the footage after Resident #6 told them about the interaction with the unidentified (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	female CNA. Resident #6's relative stated she heard the CNA offer him water instead of soda. Resident #6's relative stated Resident #6's family was upset because they felt the facility was not respecting the resident's wishes. During an interview on 02/17/2026 at 1:40 p.m., CNA G stated she was trained on abuse, neglect, and resident rights and understood the facility was Resident #6's home. CNA G stated she knew the resident already had a soda and thought it would be best for her to offer him water. She stated she should have provided the soda and recognized the resident had the right to request and receive it. She stated she acted on her own judgment at the time. CNA G stated she should have consulted with the charge nurse to get directions regarding resident requests. During an interview on 02/17/2026 at 1:49 p.m., CNA H stated he was with CNA G when Resident # 6 requested a soda and CNA G did not provide it. CNA H stated he felt it was wrong of CNA G for not asking a supervisor if the resident could have a soda and said that it could cause the resident to get upset and feel his choices were not being taken into consideration. During an interview on 02/17/2026 at 2:30 p.m., the DON stated residents had the right to make choices regarding food and beverage preferences unless medically contraindicated. The DON stated there were no indications in Resident # 6's care plan that he was not able to have a soda at night and stated the facility was Resident #6's home and it was their right to have a soda or a snack, even in the middle of the night, unless it was contraindicated by the doctor for a medical reason. The DON stated CNA G should have respected Resident #6's wishes and requests. During an interview on 02/17/2026 at 3:20 p.m., the Administrator stated Resident #6 should have been given his soda if he wished one at night. The Administrator stated if a resident had no health-related condition and, if not indicated on their care plan, all staff were responsible for respecting the resident's wishes. The Administrator stated it was possible the resident could feel frustrated. The Administrator stated it was wrong for a CNA to make a decision without consulting a charge nurse or the resident's care plan. Record review of the facility's policies and procedures titled Resident Rights, not dated, mentioned in part: The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this policy.A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.The facility will provide the Resident Rights to each newly admitted resident and upon any revision to the Resident Rights to each resident and/or resident representatives.Exercise of Rights - The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Self-determination - The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice. The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, plan of care and other applicable provisions of this part.The resident has the right to make choices about aspects of his or (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her life in the facility that are significant to the resident. Food and Nutrition services as required.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a care plan for each resident that includes the instructions needed to provide effective and person-centered care of the residents that meet professional standards of quality care for 6 (Residents #1, #2, #3, #7, #8 and #9) of 14 residents reviewed for care plans and assessments. -The facility failed to conduct a safety smoking assessment for Residents 1, 2, 3 and 8. -The facility failed to update Residents 1, 2, 3 and 8's care plans to include they smoked and were able to safely smoke. These failures could place residents at risk of not having care needs met regarding smoking supervision which could result in health complications.Findings included: 1. Record review of Resident #1's face sheet, dated 02/13/2026, revealed a [AGE] year-old male admitted [DATE] and readmitted [DATE]. Record review of Resident #1's history and physical, dated 01/26/2026, revealed a social history of daily tobacco use. The assessment included osteomyelitis with amputation of 3rd toe right foot (bone infection requiring removal of toe), hypertension (high blood pressure), dyslipidemia (abnormal cholesterol levels), peripheral arterial disease (narrowing of leg arteries reducing blood flow), peripheral vascular disease (poor circulation), benign prostatic hyperplasia (enlarged prostate), coronary artery disease (blocked heart arteries), type 2 diabetes mellitus (high blood sugar), pain (physical discomfort), impaired mobility (difficulty moving independently), and protein calorie malnutrition (poor nutrition). The documentation reflected chronic tobacco use. Record review of Resident #1's admission MDS assessment, dated 01/27/2026, revealed diagnoses including Nicotine Dependence (addiction to tobacco), cognitive communication deficit (difficulty processing or expressing thoughts), muscle Weakness (reduced strength), unsteadiness on Feet (impaired balance), and Impaired Mobility (difficulty ambulating). The MDS reflected physical limitations including left below-knee amputation and toe amputations, which impaired mobility and safe ambulation to and from designated smoking areas. The MDS revealed Resident # 1 required substantial to maximal assistance (staff does more than [NAME] the effort) for upper body dressing (the ability to dress and undress above the waist; including fasteners, if applicable) Record review of Resident #1's care plan, dated 01/26/2026, revealed focus areas including Hypertension (high blood pressure), Diabetes Mellitus (high blood sugar), Anticoagulant Therapy (blood thinning medication increasing bleeding risk), Impaired Cognitive Function (difficulty thinking clearly), ADL Self Care Deficit (difficulty performing daily activities), and Enhanced Barrier Precautions (infection control measures requiring gown and gloves). The care plan included education regarding the adverse effects of tobacco. Further record review revealed care plans did not reflect specific smoking supervision interventions, designated smoking area assistance, lighter control measures, fire prevention strategies, or individualized hazard mitigation despite the residents' nicotine dependence and impaired mobility. During an interview on 02/13/2026 at 2:38 p.m., Resident #1 stated he smoked outside in the designated smoking area. Resident #1 stated he started smoking about a week after his admission into the facility and stated he did not know if the facility evaluated him for smoking safety. Resident #1 stated he requested a staff member take him outside to. Resident #1 stated he did not remember if he was educated on the facility's policies and procedures regarding smoking and said he did not know he needed to let the facility staff know he wished to start smoking. 2. Record review of Resident #2's face sheet, dated 11/26/2025, revealed a [AGE] year-old male initially admitted on [DATE] and readmitted on [DATE]. Record review of Resident #2's history and physical, dated 02/20/2025, revealed diagnoses including congestive heart failure (chf) (a condition where the heart does not pump blood effectively), chronic kidney disease (ckd) (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(long-term damage to the kidneys that reduces their ability to filter waste), pleural effusion (fluid buildup around the lungs), depression (persistent feelings of sadness), anxiety (excessive worry or nervousness), nicotine dependence (addiction to tobacco products), atherosclerotic heart disease (hardening and narrowing of the heart arteries), hypokalemia (low potassium levels in the blood), muscle wasting (loss of muscle mass and strength), dysphagia (difficulty swallowing), gait abnormalities (problems with walking or balance), protein calorie malnutrition (lack of proper nutrition causing weight and muscle loss), acute pulmonary edema (sudden fluid buildup in the lungs), respiratory failure with hypoxia (inability to breathe adequately with low oxygen levels), pneumonia (lung infection), hypertension (high blood pressure), anemia (low red blood cell count), and schizophrenia (chronic mental disorder affecting thinking and behavior).Record review of Resident #2's MDS quarterly assessment, dated 01/06/2026, revealed completion by the RN Assessment Coordinator and included evaluation of medications, high-risk drug classes, and clinical status indicators.Record review of Resident #2's care plan, dated 02/21/2025 with revisions through 01/29/2026, revealed interventions for congestive heart failure (CHF) (a condition where the heart does not pump blood effectively) and COPD (chronic obstructive pulmonary disease) (a chronic lung disease that makes breathing difficult) including oxygen therapy (use of supplemental oxygen to assist breathing), monitoring for respiratory distress (watching for signs of trouble breathing), lab monitoring (regular blood testing to check health status), fall precautions (measures to prevent falls), skin integrity interventions for pressure ulcer prevention (steps to prevent skin breakdown and bedsores), antidepressant medication monitoring, and pain. Record review of Resident #3's face sheet, dated 02/03/2026, revealed a [AGE] year-old female with an admission date of 01/07/2026. Record review of Resident #3's admission MDS assessment, dated 01/13/2026, revealed intact cognition with a BIMS score of 15, indicating she was able to make daily decisions independently. Record review of Resident #3's care plan dated 01/07/2026 revealed the care plan was updated on 02/13/2026. The revised care plan revealed the resident was a smoker and that she would be able to smoke without causing injuries calling for interventions including for staff to ensure smoking occurred in the designated smoking area, to ensure there was no oxygen located in the smoking area while the resident was smoking, to ensure Resident #3 was made aware of the facility smoking policy, that no smoking materials were stored in the resident's room and that a safe smoking assessment was conducted every month. The care plan revealed that Resident #3 needed to be always supervised by a visitor or a facility staff member. In an interview on 02/13/2026 at 10:44 AM with Resident #3, stated she smoked, knew where the smoking area was and staff kept her cigarettes and lighter. Resident # 3 stated staff were responsible for lighting her cigarettes as well. 4. Record Review of Resident #8's face sheet 02/03/2026revealed a [AGE] year-old female with an original admission date of 06/28/2024 and a readmission date of 02/05/2022. Record Review of Resident #8's history and physical, dated 06/06/2025, revealed Resident #8 was a [AGE] year-old with diagnoses including seizure disorder (condition causing episodes of abnormal electrical activity in the brain resulting in seizures), essential hypertension (high blood pressure), hypothyroidism (underactive thyroid gland), Type 2 diabetes mellitus with hyperglycemia (high blood sugar), bipolar disorder (mental health condition causing mood swings), metabolic encephalopathy (brain dysfunction caused by metabolic imbalance), anxiety disorder (persistent excessive worry), diabetic neuropathy (nerve damage caused by diabetes), chronic pain (long-lasting pain), obesity (excess body weight), pulmonary nodule (small growth in the lung), GERD (acid reflux disease), diabetic retinopathy (eye damage caused by diabetes), acute respiratory failure with hypoxia (inability to get enough oxygen into the blood), and altered mental status (change in awareness or thinking). The record indicated the resident denied (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tobacco use. There was no documentation identifying the resident as a smoker. Record review of Resident #8's quarterly MDS, dated [DATE], revealed the resident had a BIMS score of 12 (indicating moderately impaired cognition). The MDS indicated the resident required supervision with eating, transfers, and toileting. The resident was noted to have impaired vision (difficulty seeing regular print) and required corrective lenses. There was no documentation within the MDS identifying the resident as a smoker. There was no smoking status documented, and no smoking assessment completed. Resident #8 had seizure disorder (condition causing sudden uncontrolled electrical disturbances in the brain), which increased risk for sudden episodes of loss of awareness and injury. Additionally, the resident had diabetic neuropathy (nerve damage resulting in decreased sensation), impaired vision (reduced ability to see clearly), and chronic pain (persistent pain lasting longer than expected healing time), all of which increased risk for accidents and injury. Record review of Resident #8's care plan, dated 02/03/2026, revealed focus areas for hypertension (high blood pressure), diabetes (high blood sugar), diuretic therapy related to edema (fluid swelling), impaired visual function related to diabetic retinopathy (eye damage from diabetes), depression (persistent sadness), and ADL self-care deficit (difficulty performing daily activities). The care plan included education regarding the adverse effects of tobacco; however, there was no specific problem statement identifying the resident as a smoker, no documented smoking risk assessment, and no interventions addressing supervision, safe smoking location, or monitoring for smoking-related hazards. In an observation and interview on 02/13/2026 at 10:04 AM, Resident #7 was lying on bed watching TV. Resident #7 admitted to be a smoker and showed this investigator he had a pack of cigarettes in the pocket of his jacket. Resident #7 stated he had just got the pack of cigarettes from a family member and that he was to turn it into the facility for safekeeping. Resident #7 stated he did not had a lighter or matches in his possession and said he was aware of the policies and procedures from the facility which stated resident should not keep these items with them and to turn them into the facility upon buying them for safety purposes. In an observation and interview on 02/13/2026 at 10:15 AM, Resident #9 was on his bed watching TV. Resident #9 stated he did not know he needed to let the facility know that he smoked and that to his knowledge, he had not been evacuated to safely smoke. Stated that he knew that he could not smoke inside the facility and that he needed to go outside to the designated smoking area to be able to smoke. Resident #9 had a pack of cigarettes in his nightstand drawer, and he had a lighter inside the pack of cigarettes. Resident #9 stated he knew he needed to give the smoking equipment to the facility staff and said the pack of cigarettes and lighter he had on him was because a family member had given them to him the previous day. During an interview on 02/13/2026 at 10:44 a.m., Resident #3 revealed she smoked, knew where the smoking area was and staff kept her cigarettes and lighter. Resident # 3 stated staff were responsible for lighting her cigarettes as well. In an observation and interview on 02/13/2026 at 11:37 a.m., Resident #8 was observed in the smoking area sitting on a bench with other residents who were smoking. Resident #8 stated she started smoking about two weeks ago and she had just gone to the smoking area and was given cigarettes by other residents. Resident #8 said she did not know if she was evaluated by the facility to safely smoke and stated she did not know the facility's rules for smoking, other than she needed to go outside the facility to the smoking area and that she was not allowed to smoke inside the facility.Resident #1 was observed smoking sitting close to Resident #8. It was observed that CNA A lit Resident #1's cigarette and asked him if he needed help to smoke because his hand was shaking. Resident #1 said he could do it on his own and CNA A said ok, just be careful. In an interview on 02/13/2026 at 1:54 PM with Resident #2, he stated he smoked and had no problems with smoking, holding a cigarette and disposing of ashes. He stated he (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	smoked outside the facility at the designated smoking area and that staff provided his cigarettes and they would light them up for him. Resident #2 stated he did not know if he was assessed to safely smoke at the facility. During an interview on 02/13/2026 at 12:13 p.m., CNA A stated she assisted with overseeing residents during designated smoking times and reported that nursing informed staff which residents were permitted to smoke. She stated cigarettes and lighters were kept in a locked box and staff handed out cigarettes and supervised residents while smoking. CNA A stated she did not know which residents completed smoking assessments and who had not, and she stated she was concerned that some Resident #1 may not have appropriate or safe smoking assessments in place. She stated she was concerned about residents with tremors and poor hand control while smoking and feared the risk of burns or potential fire hazards. CNA A indicated she had informed nursing of her concerns and emphasized that smoking safety remained an ongoing concern among staff due to the potential for injury or fire.During an interview on 02/13/2026 at 3:51 p.m., the Activities Director stated the facility was not following its policies and procedures for the resident's safety and that residents with smoking equipment, such as lighters, in their rooms could potentially result in fire hazards or burns. The Activities Director stated all staff in the facility were responsible for checking the safety of the residents and to immediately report to the administrator if they saw a resident having a lighter or cigarettes in their rooms to prevent fire hazards. Record review of the facility's Nursing Policy and Procedure Manual titled, Comprehensive Care Planning, not dated, stated in part: The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Comprehensive care plans may include but are not limited to resident Kardex records, baseline care plans, and task listings.The comprehensive care plan will describe the following:Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs. The resident's care plan will be reviewed after each Admission, Quarterly, Annual and/or Significant Change MDS assessment, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents choices for 7 (Residents #1, #2, #3, #5, #7, #8 and #9) of 14 residents reviewed for quality of care. The facility failed on 02/12/2026 to ensure CNA C communicated to the Charge Nurse or DON of Resident #5's fall.This failure could place residents at risk of not having care needs met, which could result in health complications.Findings included: Resident #1: Record review of Resident #1's face sheet dated 02/13/2026 revealed a [AGE] year-old male with an initial admission date of 03/31/2022 and readmitted on [DATE]. Record review of Resident #1's history and physical dated 01/26/2026 revealed a social history of daily tobacco use. The assessment included Osteomyelitis with Amputation of 3rd Toe Right Foot (bone infection requiring removal of toe), Hypertension (high blood pressure), Dyslipidemia (abnormal cholesterol levels), Peripheral Arterial Disease (narrowing of leg arteries reducing blood flow), Peripheral Vascular Disease (poor circulation), Benign Prostatic Hyperplasia (enlarged prostate), Coronary Artery Disease (blocked heart arteries), Type 2 Diabetes Mellitus (high blood sugar), Pain (physical discomfort), Impaired Mobility (difficulty moving independently), and Protein Calorie Malnutrition (poor nutrition). The documentation reflected chronic tobacco use. Record review of Resident #1's admission MDS assessment dated [DATE] revealed diagnoses including Nicotine Dependence (addiction to tobacco), Cognitive Communication Deficit (difficulty processing or expressing thoughts), Muscle Weakness (reduced strength), Unsteadiness on Feet (impaired balance), and Impaired Mobility (difficulty ambulating). The MDS reflected physical limitations including left below-knee amputation and toe amputations, which impaired mobility and safe ambulation to and from designated smoking areas. Record review of Resident #1's care plan dated 01/26/2026 revealed focus areas including Hypertension (high blood pressure), Diabetes Mellitus (high blood sugar), Anticoagulant Therapy (blood thinning medication increasing bleeding risk), Impaired Cognitive Function (difficulty thinking clearly), ADL Self Care Deficit (difficulty performing daily activities), and Enhanced Barrier Precautions (infection control measures requiring gown and gloves). The care plan included education regarding the adverse effects of tobacco; however, the documentation did not clearly reflect specific smoking supervision interventions, designated smoking area assistance, lighter control measures, fire prevention strategies, or individualized hazard mitigation despite the residents' nicotine dependence and impaired mobility. Resident #2 Record review of Resident #2's face sheet dated 11/26/2025 revealed a [AGE] year-old male initially admitted on [DATE] and readmitted on [DATE]. Record review of Resident #2's History and Physical dated 02/21/2025 revealed diagnoses including Nicotine Dependence (tobacco addiction), COPD (chronic lung disease causing breathing difficulty), Respiratory Failure with Hypoxia (inadequate oxygen levels in the blood), Pneumonia (lung infection), Pulmonary Edema (fluid in the lungs), Pleural Effusion (fluid around the lungs), Chronic Kidney Disease Stage 5 (advanced kidney failure), Anemia (low red blood cell count), and Bipolar Disorder (mood disorder with mood swings). Although Nicotine Dependence was listed as a diagnosis, the H&P documented under Social History that the resident denied tobacco use, creating inconsistency in smoking documentation. Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed a BIMS score of 14 indicating intact cognition with mild recall difficulty. The MDS section I - Active Diagnoses revealed Resident #2 had debility, cardiorespiratory conditions (medical problems that affect breathing and blood circulation). Record review of Resident #2's Care Plan dated 01/29/2026 revealed a problem area addressing coronary artery disease (condition where the blood vessels that supply blood to the heart, called (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	coronary arteries, become narrowed or blocked due to buildup of plaque (fat, cholesterol, and other substances) and included an intervention to 'encourage resident to refrain from smoking.' However, the care plan did not include a specific smoking supervision plan, designated smoking area guidance, staff supervision requirements, smoking safety precautions, lighter control procedures, or fire risk mitigation interventions. No individualized smoking safety assessment was identified despite the documented diagnosis of Nicotine Dependence. Record review of Resident #2's assessments revealed the facility did not have a safe smoking assessment on their electronic records. Resident #3 Record review of Resident #3's face sheet dated revealed a [AGE] year-old female with an admission date of 01/07/2026. Record review of Resident #3's History and Physical dated 01/07/2026 revealed a Resident #3 was a [AGE] year-old female with a history of chronic smoking, lung nodule (small abnormal lung growth), physical debility (overall body weakness), anxiety (excessive worry), and insomnia (sleep disturbance). The history and physical revealed a history of respiratory health issues, substance use disorder, and smoking safety. Record review of Resident #3's admission assessment MDS dated [DATE] revealed intact cognition with a BIMS score of 15, indicating she was able to make daily decisions independently. However, the MDS did not clearly document smoking behaviors or specify supervision requirements related to tobacco use. The absence of detailed smoking risk documentation contrasted with the Safe Smoking Assessment indicating supervision was required. Record review of Resident #3's care plan dated 01/07/2026 revealed the care plan was updated on 02/13/2026. The revised care plan revealed the resident was a smoker and that she would be able to smoke without causing injuries calling for interventions including for staff to ensure smoking occurred in the designated smoking area, to ensure there was no oxygen located in the smoking area while the resident was smoking, to ensure Resident #3 was made aware of the facility smoking policy, that no smoking materials were stored in the resident's room and that a safe smoking assessment was conducted every month. The care plan revealed that Resident #3 needed to be always supervised by a visitor or a facility staff member.Resident #5Record review of Resident #5's admission Record, 09/12/2026 revealed Resident #5 was a [AGE] year-old male, admitted [DATE], and readmitted [DATE] from an acute (a sudden change in a resident's condition that is severe, new, or rapidly worsening and requires immediate medical attention) care hospital.Record review of Resident #5's History and Physical, dated 01/02/2026, revealed diagnoses of nondisplaced intertrochanteric fracture of the left femur (a break in the upper part of the thigh bone near the hip that did not shift out of place), atrial fibrillation (an irregular and often rapid heart rhythm), altered mental status (a change in awareness, thinking, or alertness), legal blindness (severe vision loss meeting legal criteria), repeated falls (a history of falling multiple times), mild dementia (cognitive decline affecting memory and judgment), type 2 diabetes mellitus (a chronic condition causing elevated blood sugar), hypokalemia (low potassium levels in the blood), and essential hypertension (high blood pressure).Record review of Resident #5's significant change in status MDS assessment, dated 01/08/2026, revealed a BIMS score of 01, indicating severe cognitive impairment and impaired decision-making ability. Record review of Section GG, Functional Abilities and Goals, revealed the resident required assistance with bed mobility, transfers, and ambulation. The MDS revealed Resident # 5 required staff assistance for sit-to-lying, lying-to-sitting, sit-to-stand, chair/bed-to-chair transfers, and walking activities.Record review of Resident #5's Care Plan, dated 12/02/2025, revealed the resident was identified as at risk for falls. The care plan included goals that the resident would be free of falls and would not sustain serious injury. Resident #5's care plan revealed listed interventions included ensuring the call light was within reach and encouraging its use, providing education regarding safety measures and actions to take if a fall occurred, encouraging (continued on next page)

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	455471	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Health & Rehabilitation	1600 Muchison Rd El Paso, TX 79902

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	participation in activities to promote strengthening and improved mobility, ensuring appropriate footwear during ambulation, keeping furniture locked and needed items within reach, and providing staff assistance with transfers (staff x1). Resident #8 Record Review of Resident #8's face sheet revealed a [AGE] year-old female with an original admission date of 06/28/2024 and a readmission date of 02/05/2022. Record Review of Resident #8's history and physical dated 06/06/2025 revealed Resident #8 was a [AGE] year-old long-term care resident with diagnoses including seizure disorder (condition causing episodes of abnormal electrical activity in the brain resulting in seizures), essential hypertension (high blood pressure), hypothyroidism (underactive thyroid gland), Type 2 diabetes mellitus with hyperglycemia (high blood sugar), bipolar disorder (mental health condition causing mood swings), metabolic encephalopathy (brain dysfunction caused by metabolic imbalance), anxiety disorder (persistent excessive worry), diabetic neuropathy (nerve damage caused by diabetes), chronic pain (long-lasting pain), obesity (excess body weight), pulmonary nodule (small growth in the lung), GERD (acid reflux disease), diabetic retinopathy (eye damage caused by diabetes), acute respiratory failure with hypoxia (inability to get enough oxygen into the blood), and altered mental status (change in awareness or thinking). The record indicated that the resident denied tobacco use. There was no documentation identifying the resident as a smoker. There was no evidence of a smoking assessment completed. Record review of Resident #8's quarterly MDS dated [DATE] revealed the resident had a BIMS score of 12 (indicating moderately impaired cognition). The MDS indicated the resident required supervision with eating, transfers, and toileting. The resident was noted to have impaired vision (difficulty seeing regular print) and required corrective lenses. There was no documentation within the MDS identifying the resident as a smoker. There was no smoking status documented, and no smoking assessment completed. Resident #8's had seizure disorder (condition causing sudden uncontrolled electrical disturbances in the brain), which increased risk for sudden episodes of loss of awareness and injury. Additionally, the resident had diabetic neuropathy (nerve damage resulting in decreased sensation), impaired vision (reduced ability to see clearly), and chronic pain (persistent pain lasting longer than expected healing time), all of which increased risk for accidents and injury. Record review of Resident #8's care plan dated 02/03/2026 revealed focus areas for hypertension (high blood pressure), diabetes (high blood sugar), diuretic therapy related to edema (fluid swelling), impaired visual function related to diabetic retinopathy (eye damage from diabetes), depression (persistent sadness), and ADL self-care deficit (difficulty performing daily activities). The care plan included education regarding the adverse effects of tobacco; however, there was no specific problem statement identifying the resident as a smoker, no documented smoking risk assessment, and no interventions addressing supervision, safe smoking location, or monitoring for smoking-related hazards. Record review on 2/13/26 at 2:38 PM of Resident #8's assessment conducted by the facility revealed the facility did not have records for this resident on safely smoking assessments. Resident # 9Record review of Resident #9's admission Record, 02/02/2026 revealed he was a [AGE] year-old male admitted on [DATE]. Record review of Resident #9's History and Physical, dated 10/01/2025, revealed a past medical history significant for dementia (a decline in memory and reasoning abilities), hypertension (high blood pressure), hyperlipidemia (elevated cholesterol levels), diabetes mellitus type 2 (high blood sugar due to insulin resistance), arthritis (joint inflammation and pain), atrial fibrillation (irregular heartbeat that increases stroke risk), gastroesophageal reflux disease (chronic acid reflux), and cognitive communication deficit (difficulty processing or expressing language). The social history section documented that he denied smoking at the time of admission. Record review of Resident #9's MDS Quarterly Assessment, dated 01/05/2026, revealed a BIMS score of 12, which indicated moderate cognitive (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to smoke because his hand was shaking. Resident #1 said he could do it on his own and CNA A said ok, just be careful. In an interview on 02/13/2026 at 1:54 PM with Resident #2, he stated that he was a smoker and said he had no problems smoking, holding a cigarette and disposing of ashes. He stated he smoked outside the facility at the designated smoking area and that staff provided his cigarettes and they would light them up for him. Resident #2 stated he did not know if he was assessed to safely smoke in the facility. In an interview on 02/13/2026 at 12:13 PM with CNA A revealed she assisted with overseeing residents during designated smoking times and reported that nursing informed staff which residents were permitted to smoke. She explained that cigarettes and lighters were kept in a locked box and that staff handed out cigarettes and supervised residents while smoking. CNA A expressed concern that she did not know which residents from the facility had completed smoking assessments and who had not, which made her worried that some residents may not have had appropriate or safe smoking assessments in place. She reported concerns about residents with tremors and poor hand control while smoking and feared the risk of burns or potential fire hazards. CNA A stated that residents were allowed to engage in smoking activities without clear confirmation that individualized safety needs had been evaluated and implemented, potentially compromising the provision of necessary care and supervision to prevent avoidable harm. In an interview on 02/13/2026 at 12:54 PM with the DON revealed the facility had a smoking policy and that residents who identified as smokers upon admission were to receive a nursing smoking assessment to determine if they were cognitively appropriate and safe to smoke. She explained that smoking without an assessment was not permitted and that staff were expected to stop any residents from smoking until the required assessment was completed. The DON stated that failure to ensure individualized assessments and implementation of appropriate supervision could affect the facility's ability to provide care and services necessary to maintain residents' highest practicable physical health and safety. In an interview on 02/13/2026 at 2:38 PM, with Resident #1 revealed he had been smoking outside in the designated smoking area. Resident #1 stated he had started smoking about a week after his admission into the facility and stated he did not know if the facility had evaluated him for smoking. Resident #1 stated he requested a staff member to take him outside to smoke and he had been cigarettes by the staff who were outside looking after him. Resident #1 stated he did not remember if he was educated on the facility's policies and procedures regarding smoking and said he did not know he needed to let the facility staff know he wished to start smoking. In an interview on 02/13/2026 at 3:01 PM with ADON B, she stated smoking assessments should be completed immediately once a resident wished to participate in smoking. ADON B stated failure to complete assessments timely may create safety risks for residents, staff, and visitors, including potential burns or fire hazards. ADON B stated that without prompt evaluation and implementation of appropriate supervision and safety measures, residents may be exposed to avoidable harm. In an interview on 02/13/2026 at 3:09 PM with the Administrator, he stated all residents who wished to participate in smoking needed to be assessed to ensure their safety and the safety of others. He stated that if residents possessed smoking equipment without proper assessment, it could result in burns or injuries. The Administrator stated that individualized safety measures were necessary to prevent accidents and ensure residents received adequate supervision and services consistent with their needs. In an interview on 02/13/2026 at 3:51 PM with the Activities Director she stated the facility was not consistently following its policies and procedures related to resident smoking safety. She said that residents having smoking equipment such as lighters in their rooms could result in fire hazards or burns. The Activities director stated the facility failed to consistently implement safety measures necessary to prevent accidents and ensure residents received care and supervision sufficient to (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the residents' environment remained as free of accident hazards as was possible and each resident received adequate supervision to prevent accidents for 5 (Resident #1, Resident #2, , Resident #8, Resident #7 and Resident #9) of 14 residents reviewed for smoking safety. -The facility failed to conduct a safe smoking assessment for Resident #1.-The facility failed to update Resident #2's care plan for smoking.-The facility failed to ensure Resident #7 had cigarettes in his room. -The facility failed to ensure Resident #8 had a safe smoking assessment and a care plan for smoking.-The facility failed to ensure Resident #9 had a cigarette lighter in his room.-The facility failed to assess and supervise residents who smoked.Findings included: Record review of Resident #1's face sheet, dated 02/13/2026, revealed a [AGE] year-old male with an initial admission date of 03/31/2022 and readmitted on [DATE]. Record review of Resident #1's history and physical, dated 01/26/2026, revealed a social history of daily tobacco use. The assessment included Osteomyelitis with Amputation of 3rd Toe Right Foot (bone infection requiring removal of toe), Hypertension (high blood pressure), Dyslipidemia (abnormal cholesterol levels), Peripheral Arterial Disease (narrowing of leg arteries reducing blood flow), Peripheral Vascular Disease (poor circulation), Benign Prostatic Hyperplasia (enlarged prostate), Coronary Artery Disease (blocked heart arteries), Type 2 Diabetes Mellitus (high blood sugar), Pain (physical discomfort), Impaired Mobility (difficulty moving independently), and Protein Calorie Malnutrition (poor nutrition). The documentation reflected chronic tobacco use. Record review of Resident #1's admission MDS assessment dated [DATE] revealed diagnoses including Nicotine Dependence (addiction to tobacco), Cognitive Communication Deficit (difficulty processing or expressing thoughts), Muscle Weakness (reduced strength), Unsteadiness on Feet (impaired balance), and Impaired Mobility (difficulty ambulating). The MDS reflected physical limitations including left below-knee amputation and toe amputations, which impaired mobility and safe ambulation to and from designated smoking areas. Record review of Resident #1's care plan dated 01/26/2026 revealed focus areas including Hypertension (high blood pressure), Diabetes Mellitus (high blood sugar), Anticoagulant Therapy (blood thinning medication increasing bleeding risk), Impaired Cognitive Function (difficulty thinking clearly), ADL Self Care Deficit (difficulty performing daily activities), and Enhanced Barrier Precautions (infection control measures requiring gown and gloves). The care plan included education regarding the adverse effects of tobacco; however, the documentation did not clearly reflect specific smoking supervision interventions, designated smoking area assistance, lighter control measures, fire prevention strategies, or individualized hazard mitigation despite the residents' nicotine dependence and impaired mobility. Record review of Resident #2's face sheet dated 11/26/2025 revealed a [AGE] year-old male initially admitted on [DATE] and readmitted on [DATE]. Record review of Resident #2's History and Physical dated 02/21/2025 revealed diagnoses including Nicotine Dependence (tobacco addiction), COPD (chronic lung disease causing breathing difficulty), Respiratory Failure with Hypoxia (inadequate oxygen levels in the blood), Pneumonia (lung infection), Pulmonary Edema (fluid in the lungs), Pleural Effusion (fluid around the lungs), Chronic Kidney Disease Stage 5 (advanced kidney failure), Anemia (low red blood cell count), and Bipolar Disorder (mood disorder with mood swings). Although Nicotine Dependence was listed as a diagnosis, the H&P documented under Social History that the resident denied tobacco use, creating inconsistency in smoking documentation. Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed a BIMS score of 14 indicating intact cognition with mild recall difficulty. The MDS section I - Active Diagnoses revealed Resident #2 had debility, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cardiorespiratory conditions (medical problems that affect breathing and blood circulation). Record review of Resident #2's Care Plan dated 01/29/2026 revealed a problem area addressing coronary artery disease (condition where the blood vessels that supply blood to the heart, called coronary arteries, become narrowed or blocked due to buildup of plaque (fat, cholesterol, and other substances) and included an intervention to 'encourage resident to refrain from smoking.' However, the care plan did not include a specific smoking supervision plan, designated smoking area guidance, staff supervision requirements, smoking safety precautions, lighter control procedures, or fire risk mitigation interventions. No individualized smoking safety assessment was identified despite the documented diagnosis of Nicotine Dependence. Record review of Resident #2's assessments revealed the facility did not have a safe smoking assessment on their electronic records. Record review of Resident #7's face sheet, dated 01/16/2026, revealed the resident was admitted on [DATE]. Record review of Resident #7's history and physical, dated 01/16/2026, revealed he was admitted with multiple diagnoses including other acute osteomyelitis, left ankle and foot (bone infection in the left ankle and foot), type 2 diabetes mellitus with hyperglycemia (high blood sugar), Typical atrial flutter (irregular heart rhythm), Cellulitis of the left lower limb (skin infection of the left leg), muscle wasting and atrophy (loss of muscle mass), generalized muscle weakness (overall decreased strength), dysphagia (difficulty swallowing), unsteadiness on feet (poor balance), other abnormalities of gait and mobility (difficulty walking), age-related cognitive decline (memory and thinking decline associated with aging), major depressive disorder (ongoing depression), and anxiety disorder (persistent worry). The record revealed the resident had bilateral below-knee amputations (both legs surgically removed below the knees) and infections of the amputation stumps (infection at the surgical site of removed limbs). Record review of Resident #7's admission MDS assessment, dated 01/22/2026, revealed a BIMS score of 15 (indicating intact cognition). Resident #7 was coded as unsteady on feet (poor balance) and required assistance with ADLs. The MDS revealed Resident #7 required staff assistance for dressing, eating, toileting, and transfers. The resident utilized a wheelchair (mobility device for individuals unable to ambulate independently) for ambulation. Further review revealed the resident was on anticoagulant therapy related to typical atrial flutter (blood thinning medication used for irregular heart rhythm), which increased the risk of excessive bleeding if injured. The resident was also on diuretic therapy (medication that increases urination and may cause dizziness). Record review of Resident #7's Care Plan, dated 01/19/2026 and revised on 01/29/2026, revealed a focus area identifying the resident smoked. The stated goal was Resident #7 would be able to smoke without causing injury. Interventions included ensuring smoking occurred in designated smoking areas, ensuring no oxygen was located in the smoking area while the resident was smoking, ensuring the resident and/or responsible party was made aware of the facility smoking policy, prohibiting smoking materials or igniters from being stored in the resident's room, completing a Safe Smoking Assessment every month. Further record review of the care plan further revealed the resident was considered safe to smoke unsupervised. Record review of Resident #7's safe smoking assessment dated [DATE], revealed the resident knew of the location designated for smoking, that he could get to the area independently, that he was able to light, extinguish and dispose of ashes and smoking materials safely. 5. Record Review of Resident #8's face sheet revealed a [AGE] year-old female with an original admission date of 06/28/2024 and a readmission date of 02/05/2022. Record Review of Resident #8's history and physical dated 06/06/2025 revealed Resident #8 was a [AGE] year-old long-term care resident with diagnoses including seizure disorder (condition causing episodes of abnormal electrical activity in the brain resulting in seizures), essential hypertension (high blood pressure), hypothyroidism (underactive thyroid gland), Type 2 (continued on next page)

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	455471	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Health & Rehabilitation	1600 Muchison Rd El Paso, TX 79902

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diabetes mellitus with hyperglycemia (high blood sugar), bipolar disorder (mental health condition causing mood swings), metabolic encephalopathy (brain dysfunction caused by metabolic imbalance), anxiety disorder (persistent excessive worry), diabetic neuropathy (nerve damage caused by diabetes), chronic pain (long-lasting pain), obesity (excess body weight), pulmonary nodule (small growth in the lung), GERD (acid reflux disease), diabetic retinopathy (eye damage caused by diabetes), acute respiratory failure with hypoxia (inability to get enough oxygen into the blood), and altered mental status (change in awareness or thinking). The record indicated that the resident denied tobacco use. There was no documentation identifying the resident as a smoker. There was no evidence of a smoking assessment completed. Record review of Resident #8's quarterly MDS dated [DATE] revealed the resident had a BIMS score of 12 (indicating moderately impaired cognition). The MDS indicated the resident required supervision with eating, transfers, and toileting. The resident was noted to have impaired vision (difficulty seeing regular print) and required corrective lenses. There was no documentation within the MDS identifying the resident as a smoker. There was no smoking status documented, and no smoking assessment completed. Resident #8's had seizure disorder (condition causing sudden uncontrolled electrical disturbances in the brain), which increased risk for sudden episodes of loss of awareness and injury. Additionally, the resident had diabetic neuropathy (nerve damage resulting in decreased sensation), impaired vision (reduced ability to see clearly), and chronic pain (persistent pain lasting longer than expected healing time), all of which increased risk for accidents and injury. Record review of Resident #8's care plan dated 02/03/2026 revealed focus areas for hypertension (high blood pressure), diabetes (high blood sugar), diuretic therapy related to edema (fluid swelling), impaired visual function related to diabetic retinopathy (eye damage from diabetes), depression (persistent sadness), and ADL self-care deficit (difficulty performing daily activities). The care plan included education regarding the adverse effects of tobacco; however, there was no specific problem statement identifying the resident as a smoker, no documented smoking risk assessment, and no interventions addressing supervision, safe smoking location, or monitoring for smoking-related hazards. Record review on 2/13/26 at 2:38 PM of Resident #8's assessment conducted by the facility revealed the facility did not have records for this resident on safely smoking assessments. 6. Record review of Resident #9's admission Record revealed he was a [AGE] year-old male admitted on [DATE]. Record review of Resident #9's History and Physical dated 10/01/2025 revealed a past medical history significant for dementia (a decline in memory and reasoning abilities), hypertension (high blood pressure), hyperlipidemia (elevated cholesterol levels), diabetes mellitus type 2 (high blood sugar due to insulin resistance), arthritis (joint inflammation and pain), atrial fibrillation (irregular heartbeat that increases stroke risk), gastroesophageal reflux disease (chronic acid reflux), and cognitive communication deficit (difficulty processing or expressing language). The social history section documented that he denied smoking at the time of admission. Record review of Resident #9's MDS Quarterly assessment dated [DATE] revealed a BIMS score of 12, which indicated moderate cognitive impairment. The MDS reflected he was generally understood and able to understand others. Under Section I - Active Diagnoses, the MDS revealed Resident #9 had diabetes and non-Alzheimer's dementia. Under section J - Health Conditions, the MDS revealed Resident #9 had shortness of breath. Record review of Resident #9's Care Plan on 02/13/2026 at 1:32 PM revealed interventions addressing hypertension (high blood pressure), diabetes mellitus type 2 (high blood sugar levels), anticoagulant therapy (blood thinning medication used to prevent clots), GERD (acid reflux), arthritis (joint pain and stiffness), and cognitive impairment (reduced memory and judgment). The care plan included education encouraging avoidance of smoking in relation to GERD management. The care plan indicated smoking materials were kept (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at the nurses' station. The documentation did not clearly describe supervision frequency, monitoring for burns, or risk mitigation in relation to his dementia (impaired judgment), atrial fibrillation (heart rhythm disorder), or anticoagulant therapy (blood thinning medication increasing bleeding risk if injured). The care plan was updated on the date of the investigations as it did not have indications prior to the date of entrance to the facility. Record review of Resident #9's Safe Smoking assessment dated [DATE] revealed he knew the designated smoking areas and could independently access them. He was able to independently light smoking materials safely, extinguish them appropriately, and dispose of ashes properly. The assessment documented that he did not have tremors (involuntary shaking), did not fall asleep while smoking, had no prior smoking-related incidents, had no visible burn marks, and did not have finger dexterity problems (difficulty using his hands or fingers). The summary indicated he was safe to smoke unsupervised at that time. All smoking materials were kept at the nurses' station. The evaluation had been discussed with the resident and family responsible. The smoking assessment was conducted at the date of entrance to the facility by this investigator. During an observation and interview on 02/13/2026 at 10:04 a.m., Resident #7 was lying on bed watching TV. Resident #7 said he smoked and was observed with a pack of cigarettes in the pocket of his jacket. Resident #7 stated he just got the pack of cigarettes from a family member and he was to turn it into the facility for safekeeping. Resident #7 stated he did not have a lighter or matches in his possession and said he was aware of the policies and procedures from the facility which stated a resident could not keep such items with them and was required to give them into the facility for safety purposes. During an observation and interview on 02/13/2026 at 10:15 a.m., Resident #9 was on his bed watching TV. Resident #9 stated he did not know he needed to let the facility know he smoked and, to his knowledge, he was not evaluated to safely smoke. Resident #9 stated that he knew that he could not smoke inside the facility and that he needed to go outside to the designated smoking area to smoke. Resident #9 was observed with a pack of cigarettes in his nightstand drawer and a lighter inside the pack of cigarettes. Resident #9 stated he knew he needed to give the smoking equipment to the facility staff and said the pack of cigarettes and lighter he had on him was because a family member had given them to him the previous day. During an observation and interview on 02/13/2026 at 11:37 AM, Resident #8 was observed in the smoking area sitting on a bench at proximity to other residents who were smoking. CNA A remained in the smoking area with all residents throughout the smoking break. Resident #8 did not smoked during this observation. Resident #8 stated she had started smoking about two weeks ago and she had just gone to the smoking area and was given cigarettes by other residents. Resident #8 said she did not know if she had been evaluated by the facility so she could safely smoke and stated she did not know the facility's rules for smoking, other than she needed to go outside the facility to the smoking area and that she was not allowed to smoke inside the facility. Resident #1 was observed smoking sitting close to Resident #8. It was observed that CNA A lit Resident #1's cigarette and asked him if he needed help to smoke because his hand was shaking. Resident #1 said he could do it on his own and CNA A said ok, just be careful. CNA A remained in the smoking area with all residents throughout the smoking break. Resident # 1's was able to smoke on his own during the observation and was observed dropping ashes into the ash tray. In an interview on 02/13/2026 at 1:54 PM with Resident #2, he stated that he was a smoker and said he had no problems smoking, holding a cigarette and disposing of ashes. He stated he smoked outside the facility at the designated smoking area and that staff provided his cigarettes and they would light them up for him. Resident #2 stated he did not know if he was assessed to safely smoke in the facility. During an interview on 02/13/2026 at 12:13 p.m., CNA A stated she assisted with overseeing residents during designated smoking (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	times and reported that nursing informed staff which residents were permitted to smoke. She stated cigarettes and lighters were kept in a locked box and staff handed out cigarettes and supervised residents while smoking. CNA A stated she did not know which residents completed smoking assessments and who had not, and she stated she was concerned that some residents may not have appropriate or safe smoking assessments in place. She stated she was concerned about residents with tremors and poor hand control while smoking and feared the risk of burns or potential fire hazards. CNA A indicated she had informed nursing of her concerns and emphasized that smoking safety remained an ongoing concern among staff due to the potential for injury or fire. In an interview on 02/13/2026 at 12:54 PM with the DON revealed the facility had a smoking policy and that residents who identified as smokers upon admission were to receive a nursing smoking assessment to determine if they were cognitively appropriate and safe to smoke. She explained that smoking without an assessment was not permitted and that staff were expected to stop any residents from smoking until the required assessment was completed. The DON stated that staff often relied on routine, familiarity, and smoking schedules to determine who was allowed to smoke, rather than verifying completion of a current assessment. The DON stated that not having smoking assessment conducted on the resident placed them at risk of fire hazards as well as compromising the resident's health and safety if there was no proper assessment conducted. In an interview on 02/13/2026 at 2:38 PM, Resident #1 revealed he had been smoking outside in the designated smoking area. Resident #1 stated he had started smoking about a week after his admission into the facility and stated he did not know if the facility had evaluated him for smoking. Resident #1 stated he requested a staff member to take him outside to smoke and he had been cigarettes by the staff who were outside looking after him. Resident #1 stated he did not remember if he was educated on the facility's policies and procedures regarding smoking and said he did not know he needed to let the facility staff know he wished to start smoking. In an interview on 02/13/2026 at 3:01 PM with ADON B, she stated smoking assessments should be completed immediately once a resident initiates smoking. ADON B stated that failure to complete assessments timely may create safety risks for residents, staff, and visitors which could potentially cause harm to the residents and make their health worse. ADON B stated that residents having lighters in their rooms could potentially create a fire hazard which could result in injuries to the resident, visitors and staff from the facility. In an interview on 02/13/2026 at 3:09 PM with the Administrator, he stated that all residents in the facility who wished to participate in smoking needed to be assessed to ensure their safety and the safety of all residents and staff from the facility. He stated that if a resident had a lighter in their possession and not locked away by staff, could potentially result in fire hazards for the residents. The Administrator stated that if a resident has smoking equipment such as lighters and they have not been properly assessed, could result in them getting burned or injured. In an interview on 02/13/2026 at 3:51 PM with the Activities Director she stated that the facility was not following its policies and procedures for the resident's safety and that residents who had smoking equipment such as lighters in their rooms could potentially result in fire hazards or burns. The Activities Director stated that all staff in the facility were responsible for checking the safety of the residents and to immediately report to the administrator if they saw a resident having a lighter or cigarettes in their rooms to prevent fire hazards. Record review of the facility's policy and procedures titled, Uniform Smoke Free Policy, not dated, stated in part: Residents and employees are prohibited from smoking in any of the facility's buildings except in the designated smoking area. The designated smoking areas will be environmentally separate from all resident care areas and equipped with exhaust fans. The restrictions are intended to restrict smoking to a minimum and reduce risks to residents who smoke, (continued on next page)

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