STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waunakee Valley Senior Living	801 Klein Dr Waunakee, WI 53597

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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 0684 Level of Harm - Actual harm Residents Affected - Few	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 interview and record review, the facility did not ensure each resident received the necessary care and services in accordance with professional standards of practice to meet each resident's physical needs for 1 of 2 (R52) sampled residents.R52 had a diagnosis of CHF (Congestive Heart Failure). The facility failed to complete comprehensive assessments for R52 including daily weights, failed to consult the physician regarding R52's weight gain resulting in R52 having a change in condition requiring hospitalization for exacerbation of his CHF.Evidenced by:According to an article from The National Library of Medicine titled Congestive Heart Failure (Nursing) last updated 11/5/23, .Monitoring: Patients with HF require frequent monitoring of vital signs, including oxygen saturation .Frequent assessment and monitoring for symptoms is also indicated. All patients with HF require daily weight monitoring . Congestive Heart Failure (Nursing) - StatPearls - NCBI Bookshelf (nih.gov)According to the American Heart Association, daily weights should be tracked daily, stating Many people first realize their heart failure is getting worse when they notice gaining more than two or three pounds in a day or more than five pounds in a week. This gain may be due to retaining fluids since the heart is not working properly. It's good to track your weight and check in with your health care professional if you notice sudden changes. Make sure you know how much weight gain your health care professional considers a problem for you. Managing Heart Failure Symptoms (heart.org)According to the Cleveland Clinic, weight gain is a common symptom of congestive heart failure and weight tracking should be done daily. (Clevelandclinic.org).The facility policy titled, Guidelines for Weight Tracking states, in part:*Residents will have their weight taken and recorded upon admission to establish a baseline.*Unless otherwise indicated or ordered by the physician the resident will have their weight taken and recorded monthly.*The weight should be recorded in the individual resident medical record.*The physician, resident representative and dietitian shall be notified of a weight variance of 5% in 30 days, 7.5% in 90 days, and 10% in 180 days. The facility does not have a policy that governs CHF, but rather uses general standards of practice, as stated by CSN C (Clinical Support Nurse) and DON B (Director of Nursing) on 4/9/26 at 2:56 PM.R52 was admitted to the facility from the hospital on 9/10/25 and has diagnoses that include congestive heart failure, hypertension, obstructive sleep apnea, and respiratory failure.R52's hospital discharge paperwork notes a discharge diagnosis of cardiomyopathy, atrial fibrillation, and heart failure with reduced ejection fraction. This discharge summary also notes that R52's weight on 9/10/25 was 248 lbs (pounds). Additionally, this discharge paperwork states, Notify physician if patient's weight increases or decreases by 3 lbs in one day or 3 lbs in one week.The facility's admission orders, which were signed by the physician on 9/12/25, state, Resident classified as being morbidly obese related to BMI (body mass index) and comorbidities. Nursing to monitor weight and intakes as ordered.R52's TAR (Treatment administration record) indicates resident has a dx(diagnosis) of respiratory failure, observe for SOB (shortness of breath), restlessness, fatigue, rapid breathing, elevated heart rate, notify physician of new/worsening symptoms, this was signed out twice daily from 9/10-9/30/25 and 10/1/25 through 10/13/25.R52 was not weighed from 9/10/25 through 9/22/25.R52 was not weighed at the facility until 9/23/25 as evidenced by a 9/24 progress note from the registered dietician who (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 0684 Level of Harm - Actual harm Residents Affected - Few	wrote, Wt. 260 lbs (9/23).acute weight 248 lbs triggering resident for a +12 pound significant weight gain x2 weeks. Expect weight flux due to CHF/diuretic therapy.Will continue to monitor and advise on changes to nutrition interventions PRN (as needed)/quarterly.There is no evidence, nor was any documentation provided to Surveyors that the physician was updated at this time.On 9/24/25 R52 had a weight of 261 lbs(of note: this is a13-pound weight (wt.) gain compared to R52's weight 14 days prior. No evidence of physician notification being completed.)No evidence provided of weights being obtained from 9/25/25 through 10/1/25, and no evidence provided of Nursing staff monitoring/assessing R52 for signs/symptoms of CHF exacerbation or monitoring R52's edema. On 10/1/25, R52 had a weight of 249 lbs(of note: this is a 12-pound loss from 9/24/26, no evidence of an assessment or MD notification being completed)On 10/2/25 at 9:07 PM, R52's progress note indicates: Alert, oriented x 4 (person, place, time, situation). Respiratory status: regular and unlabored. Left side lung sounds clear? Yes, right side lung sounds clear? Yes. Resident has left lower extremity edema? Yes, LLE edema description: +2 resident has right lower leg edema? Yes. RLE edema description: +2.On 10/8/25, R52 had a weight of 250 lbsNo further documentation of nursing assessments/monitoring of R52 for signs/symptoms of CHF from 10/3 to 10/13/25.On 10/13/2025 at 4:20 PM the facility documented the following progress note: Doctor updated on recent declines in function, verbal responses, and increasing edema. Doctor feels he needs to be sent to ER for eval and treatment of cardiac declines that are exacerbated by his muscular disorder.On 10/13/26 R52 was admitted to the hospital with a primary diagnosis of acute exacerbation of chronic heart failure with reduced ejection fraction. The hospital notes, Etiology not entirely clear though potential diet and fluid indiscretion as unclear how closely this was being monitored prior to admission period he was given IV (intravenous) Lasix (diuretic medication used to remove excess fluid) with improvement in overall volume status. R52 was given Lasix 80mg (milligrams) IV.R52 was discharged from the hospital on [DATE] with discharge orders that state, Heart failure action plan.no weight gain of more than 3 lbs in 1 day or 5 lbs or more in a week.weigh yourself in the morning before breakfast.R52's weight on 10/17/25 was recorded at the facility as 246.5 lbs.R52 was not weighed daily from 10/18/25 through 10/25/25 despite being recently hospitalized for a CHF exacerbation and R52's hospital records indicating R52 is to weigh himself before breakfast. No evidence was provided indicating nursing staff were monitoring/assessing R52 for signs and symptoms of CHF.R52's progress note, dated 10/25/25 states, Wife in at dinner this shift and requested writer to look up his daily weights and weight recorded was on 10/17 for 246.8. Wife upset and stated they are supposed to be getting his weight every day. Writer checked and there are no orders for daily weights. Wife also requested writer to check his legs due to residents socks noted to be wet .writer completed assessment and BLE (bilateral lower extremities) noted to have 2-3 PE (pitting edema) and increased tightness at calves with weeping around ankles . Weight was obtained per wife request and is now 255. Orders were put in for a daily weight.Writer notified PCP (primary care provider) via his fax with update on status and awaiting response . writer called wife and updated her and she expressed gratitude and stated she would be putting a call into his MD and to facility administration. Writer also notified on call administration nurse. Writer did also note resident to have SOB (shortness of breath) with repositioning himself in the chair . attempted to listen to lungs. resident would not sit still and became impatient with assessment - lungs were diminished.all info sent via fax to MD . refused to apply O2 (oxygen) or BIPAP (Bilevel positive air way pressure, type of non-invasive airway treatment to help with breathing) .(of note: the physician was faxed and not called when R52 was exhibiting SOB, and diminished lung sounds)On 10/27/25, R52's physician faxed the facility requesting daily weights be sent to him and instructions to contact him if R52 were to lose 3-5 pounds over 3-5 days.On 10/27/25 at 7:11 PM, R52's progress note indicates in part: Resident returned from appt. (appointment) with new orders. orders to increase furosemide to 40mg by mouth 2x (twice) daily .BMP (basic metabolic panel) lab draw in 1 week .and daily weights. HR (heart rate) and BP (blood pressure) for acute on chronic systolic heart failure. On 4/9/26 at 1:23 PM, RN D (Registered Nurse) (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Waunakee Valley Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE 801 Klein Dr Waunakee, WI 53597	

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F 0684 Level of Harm - Actual harm Residents Affected - Few	stated that typically CHF residents are weighed daily. RN D stated that she would be concerned if there was a gain of 2 pounds in a day or 5 pounds in a week for a CHF resident and, in that case, she would do an assessment, vitals, respirations, and then call the doctor or nurse practitioner.On 4/9/26 at 1:29 PM, RN E stated that CHF residents and patients are notorious for swelling, particularly in the lower legs so she typically would monitor weights and stated that often times those are daily weights for CHF residents. RN E stated that, as a standard, a 2 pound overnight weight gain or 5 pound weight increase in a week would prompt her to intervene and contact the doctor.On 4/9/26 at 1:33 PM, LPN F (Licensed Practical Nurse) stated that usually a resident with a diagnosis of CHF is a daily weight. LPN F stated that a weight increase of 3 pounds in a day or 5 pounds in a week would trigger a re-weight and if the resident's weight is still high, she would check for edema would then contact practitioner. On 4/9/26 at 11:43 AM, Surveyor interviewed DON B who stated that the facility would not necessarily monitor weights daily, even for a resident with a diagnosis of CHF, unless there were orders to do so. When asked if weights should have been completed daily in accordance with R52's discharge paperwork from the hospital, DON B stated Yes. On 11/11/25 the facility recognized the deficient practice and immediately implemented a corrective action plan as evidenced by the following:*Education was completed with all nursing staff regarding obtaining daily weights for residents as ordered and updating the provider if weights are outside of established parameters. CNA staff were educated about the need to promptly communicate with nursing staff regarding weights. This education also included: *Why timely orders matter *Why double-checking orders is essential *Established nursing/care staff responsibilities*Best practices including entering orders immediately after receipt, confirming accuracy of orders notifying pharmacy of new orders, documenting any new/changed orders*Ensuring the resident and/or HCPOA (Healthcare Power of Attorney) are updated with any changes or new orders.Additionally, care plans were reviewed and updated for residents with CHF and those requiring daily weights.On 4/15/26 Additional information was received and reviewed.

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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 0695 Level of Harm - Actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not provide the necessary respiratory care and services 1 of 1 (R52) sampled residents.R52 had orders to use Bilevel Positive Airway Pressure (BIPAP), BIPAP settings were not transcribed, and the facility did not ensure staff had the right settings for usage, did not ensure it was being worn, and did not contact R52's physician after refusals to wear the BIPAP, no evidence of Risk. Vs benefits being provided regarding refusals resulting in R52 being sent to the hospital for exacerbation of acute respiratory failure with hypoxia (low oxygen levels in the body tissues) and hypercarbia (elevated levels of carbon dioxide in the blood).Evidenced by:R52 was admitted to the facility from the hospital on 9/10/25 and has diagnoses that include congestive heart failure, hypertension, obstructive sleep apnea (OSA), and respiratory failure.R52's most recent Minimum Data Set (MDS), dated [DATE], shows a Brief Interview for Mental Status (BIMS) score of 15, indicating R52 is cognitively intact.R52's hospital discharge paperwork notes discharge diagnosis of cardiomyopathy, atrial fibrillation, and heart failure with reduced ejection fraction. hospital course: (R52) recent .chronic hypercapnic and hypoxic respiratory failure admitted with chest discomfort . Additionally, this discharge paperwork states, Please continue to wear your home cpap/bipap during times of sleepiness, unless otherwise instructed. Some medications that you may have been prescribed or were used during a procedure may increase the chance of sleep apnea complications.R52's admission orders, signed by the physician on 9/12/25, state, Order set O2-Auto BIPAP-IPAP max (blank) EPAP min (blank) with oxygen at (blank) liters at NOC (night) and as needed during the day. Additionally, these orders state R52 is to wear oxygen via nasal canula at 3 liters at bedtime.Facility administration records show this blank order (no settings filled in) and indicates that R52 wore his BIPAP daily from 9/11/25 through 10/9/25, except for on 10/4/25. This administration record indicates R52 refused his BIPAP on 10/4, 10/10, 10/11, and 10/12. It should be noted that the facility tracked R52's O2 saturation daily from 9/11/25 through 9/24/25 and then not again until 10/17/25.R52's Treatment Administration Record (TAR) indicates resident has a dx(diagnosis) of respiratory failure, observe for SOB (shortness of breath), restlessness, fatigue, rapid breathing, elevated heart rate, notify physician of new/worsening symptoms, this was signed out twice daily from 9/10-9/30/25 and 10/1/25 through 10/13/25.On 10/13/2025 at 4:20 PM the facility documented the following progress note: Doctor updated on recent declines in function, verbal responses, and increasing edema. Doctor feels he needs to be sent to ER (Emergency Room) for eval and treatment of cardiac declines that are exacerbated by his muscular disorder.R52 was sent to the ER with a primary diagnosis of acute exacerbation of chronic heart failure with reduced ejection fraction and secondary diagnoses of OSA on BIPAP. The ER documentation dated 10/13/25 states, Patient arrives with worsening hypoxia and ongoing hypercarbia. Importantly, patient on chronic BIPAP, however, does not appear patient has been on this. This would be most likely cause of exacerbation.R52 was admitted to the hospital and then discharged back to the facility on [DATE].On 10/17/25, the facility updated R52's BIPAP orders to reflect settings of 23 inhalation pressure and 16.9 exhalation pressure with 2 liters of oxygen, which is also present on the administration record for nursing staff to see. On 4/8/26 at 2:28 PM, R52 stated to Surveyor that before he came to the facility he wore his BIPAP religiously. R52 stated that he came to the facility he wasn't wearing it because it was blowing too much air or something. R52 indicated that the flow rate of the BIPAP machine was uncomfortable. Additionally, R52 said that he was not wearing his BIPAP but instead would wear his nasal canula at night.It should be noted that sleep clinic, as well as the Durable Medical Equipment (DME) provider, has remote access to R52's BIPAP. Sleep clinic documentation shows that R52 contacted the clinic on 9/23/25 stating that the pressure settings on his BIPAP were too much for him to tolerate. Additionally, this documentation shows compliance data showing that between the dates of 6/10/25 through 7/9/25, R52 wore his BIPAP (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	100% of days, averaged 10 hours and 31 minutes of daily usage, used the BIPAP >4 hours 100% of days and had an Apnea-Hypopnea Index (AHI; the number of pauses in breathing per hour) of 3.7. This compliance data shows the settings were 22/16 (Inhalation pressure/exhalation pressure). The data also showed between 8/23/25 and 9/23/25, R52 used his machine 13% of days, averaged 45 minutes of use per day, used the machine for 4 hours or longer 0 times, used the machine a total of 4 times and had an AHI score of 13. The settings during this period of time were 23/17. This information was confirmed on 4/14/26 at 2:30 PM by RD G (Registered Dietician), who works for the DME provider that supplies R52 with his BIPAP. On 4/14/26, the DME provider provided additional compliance data to Surveyors that shows that between 9/1/25 and 10/31/25, R52 wore his BIPAP for a total of 25 minutes, 0 days for greater than 4 hours and 2 days less than 4 hours. This documentation also shows R52's AHI was 16.5 at this time. Additionally, it was noted by the DME company that R52 is currently using his BIPAP daily. (Of note: the facility has it documented that R52 wore his BIPAP, but per the DME company data, R52 did not wear his BIPAP. There is no evidence of Risk vs Benefits or education being provided to R52 regarding not wearing his BIPAP prior to hospitalization. There is no evidence of the facility staff clarifying the settings for R52's BIPAP prior to hospitalization.)On 4/9/26 at 1:23 PM, RN D (Registered Nurse) stated that for residents with BIPAP machines, she is looking to see if they have any oxygen bled into it. RN D stated that she then ensures the settings are right. RN D stated that if a resident refuses the BIPAP she would reapproach a few times and ask them why they are refusing and if she was given an answer, she would note that, pass it on to the next nurse and contact the resident's physician or nurse practitioner.On 4/9/26 at 1:29 PM, RN E stated that the settings for the BIPAP machine should be in the admission orders when the resident is admitted . RN E also stated that the settings can be verified with the DME provider. On 4/9/26 at 1:33 PM, LPN F (Licensed Practical Nurse) indicated that settings would be detailed in the orders or on the administration record. LPN F stated that she doesn't often work with residents and their but would expect to see some settings for proper usage.On 4/9/26 at 2:21 PM, Surveyor interviewed DON B (Director of Nursing). When asked if the doctor should be notified if a resident is refusing their BIPAP repeatedly, DON B replied, Yes. When asked if staff should ensure settings are correct when they apply/instruct resident with the /BIPAP, DON B stated yes.The facility did not ensure R52's BIPAP had the right settings for usage, did not ensure it was being worn (according to remote data from the DME), and did not contact R52's physician after repeated refusals to wear the machine which, in part, resulted in hypercarbia and hospital admission.Cross reference F684

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview and record review, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infection. This has the potential to affect the census of 59 residents.The facility does not have monthly Infection Control Rates documented accurately and does not have Infection Control Rates documented by infection type.This is evidenced by:The facility policy Infection Prevention and Control Program (IPCP), dated 11/19/25, includes: The campus has a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases that: a. Covers all residents, staff. c. Follows accepted national standards. The campus shall designate a member of the clinical team to monitor the campus IPCP program to perform surveillance to identify, investigate, control, and prevent the spread of infection and reporting for the IPCP. b. Surveillance activities to identify, investigate, control, and prevent the spread of infection. Infections shall be tracked per hall/unit, type of infection. c. Reviews and critiques infection surveillance reports and statistics, recommending appropriate action for Healthcare Associated Infections (HAI) and Community Acquired Infections (CAI).The facility's Infection Control (IC) Rates 2025/2026 form includes:January 2026Total Resident Count - 1678Total Facility Infection - 4IC Rate - 2.38%February 2026Total Resident Count - 1516Total Facility Infection - 4IC Rate - 2.63%MarchTotal Resident Count - 1740Total Facility Infection - 1IC Rate - 0.57% (Of note: the facility would not be able to notice a specific infection type (UTI/CAUTI, Respiratory, Gastrointestinal, skin etc.,) trending up because infection rates are not broken down into different infection types.)On 4/9/26 at 10:30 AM, Surveyor interviewed DON B (Director of Nursing) regarding the facility's infection control program. DON B indicated the facility calculates the monthly infection control rates by only including residents who have a facility acquired infection. DON B stated the facility does not track infection control rates of residents admitted to the facility with an infection. DON B indicated the facility does not track infection control rates based on the type of infections. Surveyor and DON B reviewed the facility's Infection Control Rates form. Surveyor asked what the facility's infection control rates for UTIs (Urinary Tract Infections), Wounds, respiratory, etc. were in the first quarter of 2026. DON B indicated that she could not determine what the infection control rates were for the different types of infections by looking at the facility's Infection Control Rates form.The facility's Long-Term Care (LTC) Respiratory Surveillance Line list for February 2026, includes 3 residents that were positive for facility acquired COVID.The facility's Infection Tracking - Antibiotic (ATB) Surveillance Log for February 2026, includes 4 residents with a facility acquired infection.The facility's IC Rates 2025/2026 form includes only 4 total residents for February 2026.On 4/9/26 at 2:00 PM, the facility provided surveyors with a new facility Infection Control Rate form, indicating a total of 7 residents with a facility acquired infection. The updated Infection Control Rate form indicates the original Infection Control Rate form, which included only 4 residents, was not accurate.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not ensure that all residents are clinically appropriate to self-administer medications for 1 of 1 sampled residents (R10) reviewed for self-administration of medications. R10 was observed to have 3 cups of medications left on their bedside table for them to take independently. R10 does not have an assessment for self-administration of medications indicating that they are safe to administer medications independently. Evidenced by:The facility's policy titled Guidelines for Self-Administration of Medications last reviewed on 12/16/25 states in part .Procedure 1. Residents requesting to self-medicate or has self-medication as a part of their plan of care shall be assessed using the observation [Facility's Corporation Name]- Self Administration of Medication withing the electronic health record. Results of the assessment will be presented to the physician for evaluation and order for self-medication. R10 was admitted to the facility on [DATE] with diagnoses that include chronic kidney disease, malnutrition, and heart disease. R10's most recent MDS (Minimum Data Set) dated 3/27/26 states that R10 has a BIMS (Brief Interview of Mental Status) of 15 out of 15, indicating that R10 is cognitively intact. On 4/8/26 at 8:43 AM, Surveyor interviewed R10. Surveyor observed 3 medication cups with medications in them sitting on R10's bedside table. Surveyor asked R10 if staff typically leave their medications at bedside, R10 stated that if they are sleeping, staff will leave them on the table for them to take because they need to take the medications with breakfast. On 4/8/26 at 10:15 AM, Surveyor interviewed LPN F (Licensed Practical Nurse). Surveyor asked LPN F if they gave R10 their medications this morning, LPN F stated that they put the medications in R10's room and that R10 takes the medications themselves. LPN F stated that R10 is independent with their medications. Surveyor asked LPN F if R10 has an assessment for self-administering medications, LPN F stated no. Surveyor asked LPN F if R10 had a physician's order for self-administration of medications, LPN F stated that there is not a specific order for R10 to self-administer their medications. LPN F reported that R10 will not take their medications when they bring them in in the morning and states they don't want them now.Surveyor requested R10's assessment for self- administration of medications. No assessment was provided.On 4/8/26 at 4:21 PM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked NHA A if they were able to find an assessment for R10 to self-administer medications, NHA A stated no. Surveyor asked NHA A if R10's medications should be left at bedside, NHA A stated no, not without an assessment.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure adequate supervision and safety to prevent accidents from occurring for 1 of 1 resident reviewed (R8) for smoking. R8 began smoking at the facility and the facility was not able to provide documentation indicating that R8 was assessed to be a safe, independent smoker, once the facility was made aware. Evidenced by:The facility's policy titled Smoke Free Environment last reviewed on 11/20/25 does not address steps taken if a resident starts smoking once they are admitted to the facility. R8 was admitted to the facility on [DATE] with diagnoses that include malignant neoplasm of overlapping sites of right breast (breast cancer), secondary malignant neoplasm of bone (bone cancer), major depressive disorder, and bipolar disorder. R8's most recent MDS (Minimum Data Set) dated 4/2/26 states that R8 has a BIMS (Brief Interview of Mental Status) of 15 out of 15, indicating that R8 is cognitively intact. It is important to note that despite being aware of R8 smoking in July of 2025, R8's smoking status was not reflected in their MDS until 4/2/26. R8's Face Sheet states in part .Smoking status: Former smoker. R8's care plan dated 7/9/25 states in part . Problem: [R8] currently uses tobacco. Goal: Resident will safely smoke according to her ability. Approach: Assist MD/NP (Medical Doctor/Nurse Practitioner) to promote smoking cessation. Explain facility's smoking policy to resident. Remind as needed. Explain to resident where designated smoking areas are located. Remind as needed. Notify MD/NP if changes occur related to smoking as in respiratory distress or skin concerns. On 4/7/26 at 1:57 AM, Surveyor interviewed R8. R8 reported that they do smoke and that they have to go off premises and that facility staff are aware. R8 reported that they take the elevator down to a parking lot and then to the sidewalk. R8 reported that they smoke twice a day. It is important to note that surveyor requested R8's smoking assessment and none was provided. On 4/8/26 at 11:32 AM, Surveyor interviewed NHA A (Nursing Home Administrator). Surveyor asked NHA A if they have a smoking assessment for R8, NHA A stated that they are a non-smoking facility, therefore they do not have an assessment. Surveyor asked NHA A how they can be assured that a resident in their facility that smokes is safe to smoke, NHA A stated that they were unaware that R8 smoked. Surveyor asked NHA A if R8 has a care plan for smoking, should they have an assessment, NHA A stated they would have to look into it. On 4/9/26 at 8:40 AM, Surveyor interviewed R8. Surveyor asked R8 where they kept their smoking materials, R8 reported that they are in the top drawer of their dresser. Surveyor observed a pack of cigarettes and a lighter in the top drawer of R8's dresser. On 4/9/26 at 10:18 AM, Surveyor interviewed NHA A. Surveyor asked NHA A how they can be assured that R8 is able to safely store smoking material in their room, NHA A stated that they are working through that process because they were unaware. Surveyor asked NHA A if staff was aware that R8 was going outside to smoke, NHA A stated yes and that MDS Coordinator H had completed an assessment in July. Surveyor asked if the assessment was documented, NHA A stated no because there was no formal assessment in their computer system for smoking. On 4/9/26 at 10:34 AM, Surveyor interviewed MDS Coordinator H. MDS Coordinator H reported that as soon as they found out that R8 was smoking, they added a care plan. Surveyor asked MDS Coordinator H if they completed a smoking assessment, MDS Coordinator H stated yes. Surveyor asked MDS Coordinator H if they have documentation of they assessment, MDS Coordinator H stated that they do not have a smoking assessment in their computer system. Surveyor asked MDS Coordinator H if they took notes regarding the assessment, MDS Coordinator H stated no.