STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525329	A. Building B. Wing	10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rib Lake Health Services	650 Pearl St Rib Lake, WI 54470

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility did not maintain a safe and sanitary environment in which food is prepared and distributed. This had the potential to affect all 38 residents in the facility.Facility staff did not label, date, or cover food.Facility is not protecting clean dishware from contaminants. Facility staff did not keep personal clothing from touching food when serving residents.Findings include:The 2022 FDS Food Code documents at 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food: Disposition .A date marking system may be used which places information on the food, such as on an overwrap or on the food container, which identifies the first day of preparation, or alternatively, may identify the last day that the food may be sold or consumed on the premises. A date marking system may use calendar dates, days of the week, color coded marks, or other effective means, provided the system is disclosed to the Regulatory Authority upon request, during inspections.4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles.(A) Except as specified in (D) of this section, cleaned EQUIPMENT and UTENSILS,laundered LINENS, and SINGLE-SERVICE and SINGLE-USE ARTICLES shall be stored: . (2) Where they are not exposed to splash, dust, or other contamination.2-304.11 Clean Condition.Food employees shall wear clean outer clothing to prevent contamination offood, equipment, utensils, linens, and single-service and single-use articlesThe United States Public Health Service, Food and Drug Administration Food Code 2-401 Food Contamination Prevention, states in part,. F. Facility-wide ConsiderationsIn order to have active managerial control over personal hygiene and cross-contamination, certain control measures must be implemented in all phases of the operation. All of the following control measures should be implemented regardless of the food preparation process used. Prevention of cross-contamination of ready-to-eat food or clean and sanitized food-contact surfaces with soiled cutting boards, utensils, aprons, etc.,On 9/29/25 at 8:25 AM, Surveyor conducted initial Kitchen tour with Dietary Manager (DM) K. During initial tour, Surveyor observed open bags of broccoli, peas, beans, and tater tots, as well as opened ice cream in the freezer without any information written on them. Surveyor also observed opened peaches in a container without any information labeled and uncovered chicken cutlets in a pan without any information on or near the container. DM K stated the chicken should be covered and all of the open food items should be dated when opened and stored. On 9/29/25 at 8:33 AM, Surveyor observed a fan positioned on a top shelf across from the clean dishes area, blowing on the clean dishes to dry them. DM K stated he did not know fan could not be used to dry the clean dishes and verbalizes understanding of how this exposes the dishes to dust and potential other contaminants. On 9/30/25 at 11:48 AM, Surveyor observed DM K dishing up food onto residents' plates. DM K leaned forward to dish up food, and while doing so, Surveyor observed DM K's soiled clothing touch top of residents' plates and at times, residents' food. DM K stated he did not wear an apron when cooking and was unaware his clothing was touching the resident's food and plates. Immediately after observation, Surveyor interviewed DM L, who stated the expectation would be the staff's clothing does not touch the residents' plates and/or food during serving of meals.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment are reported immediately, but not later than 2 hours after the allegation is made to the administrator of the facility and to other officials in accordance with State law through established procedures for 1 resident (R8) reviewed.Facility failed to report R8's allegation of abuse/neglect to State Agency (SA) and law enforcement. Findings:The facility policy, titled Abuse, Neglect and Exploitation, revised 07/15/2022, states: Definition of Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.includes verbal abuse. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.Reporting/Response Part A(1a) states in part.reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other agencies (e.g., law enforcement when applicable) immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in bodily injury. R8 was admitted to the facility on [DATE], with diagnoses including abnormalities of gait and mobility, chronic obstructive pulmonary disease (COPD), morbid obesity, unspecified dementia and anxiety disorder. R8 has a BIMS score of 8/15, which indicates moderate cognitive impairment, and has an activated power of attorney for healthcare. On 10/01/2025 during record review of facility complaints, documentation of a grievance was found, dated 07/16/2025 and filed by Social Worker (SW) D on behalf of R8. Grievance report states:On 07/16/2025 (no time indicated), grievance was reported. Description of grievance states in part.Certified Nursing Assistant (CNA) E came in and threw off attitude with R8. CNA E then called another aide into the room to boost R8, and R8 asked not to because of some pain (from a fall R8 sustained earlier that day) and how R8 thought his leg was broken. The report further indicated R8 stating CNA E said, oh come on [R8]! and then proceeded to boost R8. R8 felt CNA E has a sour and poor attitude with R8 every time R8 needs something. On 07/22/2025, grievance report indicates SW D interviewed several other residents on southeast hall, inquiring about any concerns of abuse or neglect. No concerns of abuse/neglect identified. On 07/17/2025, R8's POA was notified of grievance regarding alleged abuse. On 08/06/2025, NHA H signed grievance reportOn 10/01/2025 at 11:45 AM, Surveyor interviewed R8 about alleged abuse/neglect incident on 07/15/2025. R8 did not recall all details of incident but did remember it happening and that CNA E was staff person involved. R8 denied having any harm as result of incident. R8 denies any further concerns of abuse/neglect with CNA E or other staff. R8 continues to allow CNA E to perform cares. R8 stated, They've had trouble with her before. She acts like she owns the place. On 10/01/2025 at 12:03 PM, Surveyor interviewed SW D about the grievance filed on 07/16/25 on R8's behalf of allegation of inappropriate interaction between CNA E and R8. SW D stated:On 07/15/25, late afternoon just prior to SW D's shift ending, CNA F and another CNA, whom SW D could not recall name for, presented with concerns of witnessing CNA E's rudeness towards R8 earlier in the day. SW D asked both CNAs to report concerns to nursing staff and to write up statements surrounding event and put reports under SW D's door to be addressed next day. SW D is not sure if CNAs did report incident to nursing staff.On 07/16/2025, at facility's routine morning meeting (SW did not recall the time) with interdisciplinary team members (IDT), SW D brought forward R8's concerns. Nursing Home Administrator (NHA) H, acting administrator at time of incident, informed SW D to speak with R8, as well as CNA E about tone of voice.On 07/16/2025, upon arrival to work, SW D had received a witness statement from CNA F. SW D states no statement from other CNA who reportedly witnessed incident on 07/16/2025 was received.On 07/16/2025, Housekeeping (HK) G arrived for shift and told SW D of overhearing CNA E speaking rudely to R8 on 07/16/2025. SW D asked HK G to write a witness statement. Statement from HK G (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was later received.On 07/17/2025 (SW D did not recall time), SW D interviewed R8 who stated CNA E was inconsiderate after R8 requested to not be boosted up in the bed because of pain. R8 told SW D that CNA E was rude and had no remorse. SW D asked if R8 preferred that CNA E no longer performs cares for him, and R8 stated, 'It's water under the bridge. I just wish she was more considerate. R8 declined SW D's offer for alternative staff to do cares. On 07/22/2025 (SW D did not recall time), SW D spoke with CNA E regarding grievance filed for incident on 07/15/2025. SW D could not recall entire conversation with CNA E but was instructed by NHA A to address CNA's mannerism and tone of voice toward R8.On 07/29/2025, SW D interviewed a surplus of residents down the Southeast Hall asking if they had any concerns with CNA E or any other staff. All residents interviewed denied having any concerns of abuse or neglect. On 10/01/2025 at 12:49 PM, Surveyor interviewed current NHA A what expectations are of staff to report any allegations of abuse/neglect. NHA A stated there is a facility policy for abuse and neglect in place and it is expected that all staff persons report abuse suspicions immediately to administrative staff or shift nurses. Shift nurses have been trained on the protocols for reporting abuse/neglect allegation immediately to the NHA/DON. NHA A stated all staff receive annual training on abuse and neglect. NHA A stated all allegations of abuse/neglect are to be reported to the state and appropriate authorities within 2 hours of acknowledgment, investigation of incident begins immediately with a completed follow up report done in 5 days. On 10/01/2025 at 1:15 PM, Surveyor interviewed former NHA H, who was acting NHA at time of incident, what expectations are of staff to report any allegation of abuse/neglect. NHA H stated if abuse/neglect was suspected, it would be reported to the state. At time of the incident, NHA H did not feel actual harm came to R8 because of the interaction between R8 and CNA E, so administration did not report the allegation of abuse or neglect to SA or law enforcement. NHA H stated SW D was asked to further interview both R8 and CNA E about their interaction, and CNA E was made aware that the interaction was interpreted as inappropriate by R8.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure alleged violations of abuse or neglect was thoroughly investigated, preventions for further abuse/neglect implemented, and corrective actions were taken as a result of investigation for 1 resident (R8) of 1 resident.Failure by the facility to thoroughly investigate R8's allegation of abuse/neglect denied protection of R8's health, welfare and rights as a resident to feel safe while residing at facility. Findings:The facility policy, titled Abuse, Neglect and Exploitation, revised 07/15/2022, states in part:Prevention of Abuse, Neglect and Exploitation - The facility will identify, correct and intervene in situations in which abuse, neglect.is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff to meet the needs of the residents.Identification of Abuse, neglect or Exploitation - The facility will have written procedures to assist staff in identifying the different types of abuse.Investigation of Alleged Abuse, Neglect and Exploitation - An immediate investigation is warranted when allegation or suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Identifying and interviewing all involved persons. focusing the investigation on determining if abuse/neglect has occurred, the extent, and cause.providing complete and thorough documentation of the investigation.R8 was admitted to the facility on [DATE] and has diagnoses that include abnormalities of gait and mobility, Chronic Obstructive Pulmonary Disease (COPD), morbid obesity, unspecified dementia and anxiety disorder.R8 has a BIMS score of 8, moderate cognitive impairment, and has an activated power of attorney for healthcare. On 10/01/2025 during record review of facility complaints, documentation of a grievance was found, dated 07/16/2025 and filed by Social Worker (SW) D on behalf of R8. Grievance report states:On 07/16/2025 (no time indicated), grievance was reported. Description of grievance states in part.Certified Nursing Assistant (CNA) E came in and threw off attitude with R8. CNA E then called another aide into the room to boost R8, and R8 asked not to because of some pain (from a fall R8 sustained earlier that day) and how R8 thought his leg was broken. The report further indicated R8 stating CNA E said, oh come on [R8]! and then proceeded to boost R8. R8 felt CNA E has a sour and poor attitude with R8 every time R8 needs something. On 07/17/2025, R8's POA was notified of grievance regarding alleged abuse.On 07/22/2025, grievance report indicates SW D interviewed other residents on southeast hall about any concerns of abuse or neglect. No concerns of abuse/neglect identified. It is noted the facility had no documentation to support who was interviewed for residents, or what was said. On 07/29/2025, grievance report documentation for actions taken to resolve grievance states SW D questioned CNA E about allegation and CNA E stated CNA E and R8 are fine and have been fine since the altercation. On 08/06/2025, NHA H signed grievance reportOn 10/01/2025, witness statement by CNA F, dated 07/15/2025, was reviewed and states that R8 told CNA F, I don't deserve to be treated poorly, talked to like I am nothing and argued with. CNA F's statement states R8 requested CNA E not to be allowed back in room because she is rough and does not care about us.On 10/01/2025, witness statement by HK G, dated 07/17/2025, stated while cleaning R8's room, R8 talked to HK G about knee pain and earlier that morning R8 told CNA E this. CNA E responded to R8, Oh [R8], it's not that bad and then turned off R8's call light and left room. R8 did not appreciate that kind of response when in pain. HK G offered to get another CNA to assist, however R8 declined. On 10/01/2025 at 11:45 AM, Surveyor interviewed R8 about alleged abuse/neglect incident on 07/15/2025. R8 did not recall all details of incident, but did remember it happening and that CNA E was staff person involved. R8 denied having any harm as result of incident. R8 denies any further concerns of abuse/neglect with CNA E or other staff. R8 continues to allow CNA E to perform cares. R8 stated, They've had trouble with her before. She acts like she owns the place.On 10/01/2025 at 12:03 PM, Surveyor interviewed SW D about the grievance filed on 07/16/25 on R8's behalf of allegation of inappropriate interaction between CNA E and R8. SW D stated:On 07/15/25, late afternoon just prior to SW D's shift ending, CNA F and another (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA, whom SW D could not recall name for, presented with concerns of witnessing CNA E's rudeness towards R8 earlier in the day. SW D asked both CNAs to report concerns to nursing staff and to write up statements surrounding event and put reports under SW D's door to be addressed next day. SW D stated not sure if CNAs reported incident to nursing staff.On 07/16/2025, at facility's routine morning meeting (SW did not recall the time) with interdisciplinary team members (IDT), SW D brought forward R8's concerns. Nursing Home Administrator (NHA) H, acting administrator at time of incident, informed SW D to speak with R8, as well as CNA E about tone of voice. It is noted there is no documentation to support participants in meeting, or issues addressed. There is no evidence that CNA E was removed from resident cares or that an investigation process was initiated. On 07/16/2025, upon arrival to work, SW D had received a witness statement from CNA F. SW D stated no statement from other CNA who reportedly witnessed incident on 07/16/2025 was received.On 07/16/2025, Housekeeping (HK) G arrived for shift and told SW D of overhearing CNA E speaking rudely to R8 on 07/16/2025. SW D asked HK G to write a witness statement. Statement from HK G was later received.On 07/17/2025 (SW D did not recall time), SW D interviewed R8 who stated CNA E was inconsiderate after R8 requested to not be boosted up in the bed because of pain. R8 told SW D that CNA E was rude and had no remorse. SW D asked if R8 preferred that CNA E no longer performs cares for him, and R8 stated, It's water under the bridge. I just wish she was more considerate. R8 declined SW D's offer for alternative staff to do cares. On 07/22/2025 (SW D did not recall time), SW D spoke with CNA E regarding grievance filed for incident on 07/15/2025. SW D could not recall entire conversation with CNA E but was instructed by NHA H to address CNA's mannerism and tone of voice toward R8On 07/29/2025, SW D interviewed a surplus of residents down the Southeast Hall asking if they had any concerns with CNA E or any other staff. All residents interviewed denied having any concerns of abuse or neglect. There is no supporting documentation of which residents were interviewedOn 10/01/2025 at 12:49 PM, Surveyor interviewed NHA A what expectations are of staff to report and investigate any allegations of abuse/neglect. NHA A stated there is a facility policy for abuse and neglect in place and it is expected that all staff persons report abuse suspicions immediately to administrative staff or shift nurses. NHA A stated all staff receive annual training on abuse and neglect recognition and reporting. NHA A stated all allegations of abuse/neglect are to be reported to the state and appropriate authorities within 2 hours of acknowledgment, investigation of incident begins immediately, which includes removal of accused staff personnel from resident care, and a completed investigative follow up report done in 5 days. NHA A was unable to provide proof of a facility reported incident for 07/15/2025, or documentation of a thorough investigation was implemented. On 10/01/2025 at 1:15 PM, Surveyor interviewed NHA H what expectations are of staff to report and investigate any allegation of abuse/neglect. NHA H stated if abuse/neglect was suspected, it would be reported to the state. At the time of the incident, NHA H did not feel actual harm came to R8 because of the interaction between R8 and CNA E, so it was not reported to appropriate agencies as abuse or neglect. NHA H stated SW D was asked to further interview both R8 and CNA E about their interaction. At time of interview, NHA H did acknowledge there was indication of abuse/neglect based off information provided by R8 and staff, and that this occurrence should have been reported to appropriate agencies with an investigative process implemented immediately.

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F 0684 Level of Harm - Minimal harm or potential for 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 interviews and record review, staff did not follow the facility's post fall assessment for 1 out of 1 resident (R26) investigated for falls.The facility did not ensure post fall neurological (neuro) checks were performed as required following R26's unwitnessed fall. Findings include:The facility's policy titled, Fall Prevention and Management Guidelines reviewed on 7/18/24, states in part, .7. When any resident experiences a fall, the facility will: a. Complete a post-fall assessment and review: . 2) Neuro checks for any unwitnessed fall or witnesses fall where resident hits their head: Initially, then hourly x 3 then continue neuro checks every 4 hours x 6, then continue neuro checks every 8 hours x 6 or as indicated by physician.R26 was admitted to the facility on [DATE] with diagnoses, which include in part, Alzheimer's disease and focal partial symptomatic epilepsy. R26's care plan includes, in part, that R26 is at risk for falls due to history of falls, past history of syncope, and possible seizures. R26 most current Minimum Data set (MDS) on 8/2/25 indicated a Brief Interview for Mental Status (BIMS) was 4/15, indicating severe cognition deficit. R26 had no impairment with range of motion (ROM), independent with ambulation and use of walker, and required partial to moderate assistance with hygiene/ bathing/dressing.Record review indicated on 8/28/25 at approximately 3:15 PM, R26 had an unwitnessed fall outside the facility in front of the building. Vital signs were taken and were recorded as the following: blood pressure: 124/75, Temperature: 98.2, pulse: 124, and respirations: 18. Resident was brought back in the building. R26 was assessed by the Director of Nursing (DON). R26 had a laceration on her left upper arm/shoulder. Provider was notified. Documentation on 8/28/25 in R26's post assessment fall documentation, states in part. 8. Care Plan, 1. List new immediate interventions. Social Service Director spoke with Power of Attorney (POA) in regard to wander guard. 1-hour checks. Date and time of interventions 8/28/25 1:45PM.Surveyor interviewed Nursing Home Administrator (NHA) A, who stated, 1-hour checks were put in the assessment by mistake. No documentation of 1 hour wandering checks on R26 were completed.R26's record review indicated neurological checks were completed as follows:On 8/28/25, initially at 3:15 PM and hourly at 4:05 PM and 5:13 PM. Neuro checks were completed initially and then hourly two time, missing the third hourly neuro check around 6 PM.Neuro checks then should have been completed every 4 hours x 6 and were completed at 9:59 PM on 8/28/25 and then not checked again until 8/29/25 at 2:59 AM and 11:27 PM. The Neuro checks should have been done at 2 AM, 6 AM, 10 AM, 2 PM, 6 PM, and 10 PM on 8/29/25. There was no documentation of neuro checks done at those times.Neuro checks then should have been completed every 8 hours x 6 at around 6 AM, 2 PM, and 10 PM on 8/30/25 and documentation shows these were done at 4:30 AM, 2:34 PM, and 4:53 PM on 8/30/25. No documentation of neuro checks for 16 hours until on 8/31/25 at 9:52 AM and then again at 5:21PM.On 10/01/25 at 8 AM, Surveyor interview NHA A, who stated she is aware there are missing post fall neurological assessments from R26's fall on 8/28/25. Although the neuro checks completed were with in normal limits and R26 did not require hospitalization, there was a potential for R26 to have had harm due to the multiple missed neuro checks.On 10/1/25 at 11:50 AM, Surveyor interviewed DON B, who stated the expectation would be that staff follow the facility's Fall Prevention and Management Guidelines as indicated for post-fall assessments.

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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 interview and record review, the facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 6 residents (R9) who smoke in the facility.R9 did not have a smoking care plan, or a nicotine assessment completed.Findings:Facility policy titled, Smoking Policy date revised 9/10/24 stated in part: .3. Residents and family members will be notified of this policy during the admission process, and as needed.4. All residents will be asked about tobacco/nicotine use during the admission process, and during each quarterly or comprehensive minimum data set (MDS) assessment process.5. Resident who smoke or use nicotine or e-cigarettes will be further assessed, using the Nicotine Assessment UDA, to determine whether supervision is required for smoking, or if resident is safe to smoke at all .7. Any resident who is deemed safe to smoke, with or without supervision, will be allowed to smoke in designated smoking areas (weather permitting), at designated times, and in accordance with his/her care plan .9. All safe smoking measures will be documented on each residents' care plan and communicated to all staff, visitors, and volunteers who will be responsible for supervising residents while smoking. Supervision will be provided as indicated on each residents' care plan .Resident (R) 9 was admitted to the facility on [DATE] with a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated R9 was cognitively intact.R9 had diagnoses of acute respiratory failure with hypoxia (the inability of the respiratory system to maintain an adequate blood oxygen level to preserve normal organ function), cerebral infarction (refers to a blood vessel blockage in the brain caused by atherosclerosis, or the hardening of arteries due to buildups of fatty deposits), and above the knee amputation of the left leg.R9 did not have a care plan to address smoking.R9 did not have a nicotine assessment in the medical chart.On 09/29/2025 at 8:39 AM, facility provided team with a list of residents in the facility who smoke. R9 was on the list of smokers.On 09/29/2025 at 9:46 AM, Surveyor asked R9 about the normal routine for smoking. R9 replied, I usually have to ask for my cigarettes. We go right out the front door to smoke. I can get from my bed to my chair pretty much on my own I just need someone here, so I don't end up on my nose.On 09/29/2025 at 1:43 PM, Surveyor was unable to find any care plan or nicotine assessment for R9 in the medical chart.On 09/30/2025 at 8:07 AM, Surveyor asked Registered Nurse (RN) I for a nicotine assessment and care plan for R9.On 09/30/2025 at 8:27 AM, RN I informed Surveyor that R9 did not initially smoke when he came in so the facility missed that assessment but have now completed that assessment so when R9 goes out again he will be ok.On 10/01/2025 at 12:44 PM, Surveyor asked License Practical Nurse (LPN) J, When did the facility know that [R9] was a smoker? LPN J replied, We knew probably a couple of days after he came to our facility. He did not go out and smoke before that that I know of. Surveyor asked LPN J, When was the nicotine assessment completed for R9? LPN J replied, I think recently that was completed. I know that all smokers are supposed to have a nicotine assessment.