STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345161	A. BUILDING ______ B. WING ______	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERNETHY LAURELS	**102 LEONARD AVENUE** **NEWTON, NC 28658**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation was conducted on 07/08/24 through 07/11/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #3VQ511.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 07/08/24 through 07/11/24. Event ID #3VQ511. The following intakes were investigated NC00218494, NC00217848, and NC00210764. 8 of the 8 complaint allegations did not result in a deficiceny.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.	F 578		8/1/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/01/2024

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.

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F 578	Continued From page 1 (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and Nurse Practitioner (NP) interviews the facility failed to ensure a resident's (Resident #32) code status election was accurate throughout the medical record for 1 of 2 residents (Resident #32) reviewed for advanced directives. The findings included: Resident #32 was admitted to the facility on 3/27/2021 with a diagnosis of heart disease. A review of a physician's order dated 7/21/2023 revealed Resident #32 was a full code. A review of a Medical Orders for Scope of Treatment (MOST) form dated 7/21/2023	F 578	Preparation and execution of this plan of correction in no way constitutes an admission or agreement by Abernethy Laurels of the truth of the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law, and because the facility has been threatened with termination from the Medicare and Medicaid programs if it fails to do so. The facility contends that it was in substantial compliance with all requirements on the survey date, and denies that any deficiency exists or existed or that any such plan is necessary. Neither the submission of such plan, nor anything	

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F 578

Continued From page 2

indicated Resident #32 wanted cardiopulmonary resuscitation (CPR, chest compressions), limited scope of treatment which included to "use medical treatment, intravenous (IV) fluids and cardiac monitoring as indicated, do not use intubation (breathing tube) or mechanical ventilation (ventilator); also provide comfort measures, transfer to the hospital if indicated, and avoid intensive care." The MOST form was signed by Nurse Practitioner (NP) #1 and completed by the Social Worker (SW).

A review of the advanced directives book at the nurse's revealed Resident #32 had a Medical Orders for Scope of Treatment (MOST) form dated 7/21/2023 which indicated Resident #32 wanted cardiopulmonary resuscitation (CPR, chest compressions), limited scope of treatment which included to "use medical treatment, intravenous (IV) fluids and cardiac monitoring as indicated, do not use intubation (breathing tube) or mechanical ventilation (ventilator); also provide comfort measures, transfer to the hospital if indicated, and avoid intensive care."

A quarterly Minimum Data Set (MDS) dated 5/28/2024 revealed Resident #32 was cognitively intact.

A review of a physician's progress note dated 7/8/2024 written by the Medical Director (MD) revealed Resident #32 wanted a full scope of treatment.

An interview was conducted on 7/9/2024 at 1:37 pm with Nurse #1. Nurse #1 stated when a resident was admitted a nurse manager would complete the MOST form and/or DNR form and place the form in the advanced directives book at

F 578

contained in the plan, should be construed as an admission of any deficiency, or of any allegation contained in this survey report. The facility has not waived any of its rights to contest any of these allegations or any other allegation or action. This plan of correction serves as the allegation of substantial compliance.

Prefix Tag: F-578
It is the intent of this facility to ensure a resident's code status election is accurate throughout the medical record.

1) How corrective action will be accomplished for those residents found to have been affected by the deficient practice

On 7/11/24, RN Care Coordinator reviewed current MOST form, explaining each section and updated per resident/resident representative's wishes.
RN Care Coordinator ensured complete understanding from resident and resident representative.
On 7/11/24, RN Care Coordinator voided current MOST form with Nurse Practitioner signature and resident signature.
On 7/11/24, new MOST form completed by RN Care Coordinator, signed by Nurse Practitioner and resident signature.
On 7/11/24, RN Care Coordinator documented updated MOST form changes in resident's medical record.

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F 578	Continued From page 3 the nurse's station. Nurse #1 verified not all residents have a MOST form and in the event of an emergency, she would refer to the order in Electronic Health Record (EHR). Nurse #1 verified Resident #32 was a "full code" in the EHR. An interview was conducted on 7/10/2024 at 8:55 am with the SW. The SW stated when a resident was admitted to the facility, she was responsible for discussing code status with the resident and/or representative and completed the MOST form. The SW stated that she would ask the resident or resident representative if they wanted to have CPR and would elect either CPR or "Do Not Resuscitate (DNR). The SW stated she then would read the scope of treatment options and elect the one the resident desired. The SW stated the facility did not require residents to have a MOST form. The SW stated after she completed the MOST form, she had a provider review and sign the form and she then would take the MOST form to medical records where it was scanned into the chart. The SW stated after Medical Records scanned the form into the chart, she delivered the form to the appropriate nursing unit, would have the resident's nurse review the form for accuracy and completion, and would put the completed form in the advanced directives book at the nurse's station. The SW stated she completed Resident #32's MOST form on 7/21/2023. The SW stated Resident #32 had elected to have CPR and she was unsure of what limitations, if any, that Resident #32 wanted. The SW verified Resident #32 had an order for "full code" in the Electronic Health Record (EHR) and agreed that the code status should match and reflect limitations. The SW stated the admitting nurse was responsible for entering the code	F 578	2) How the facility will identify other residents having the potential to be affected by the same deficient practice On 7/24/24 & 7/25/24, RN Care Coordinators completed audit to ensure accuracy of progress notes and current MOST forms. On 7/26/24, Social Workers identified residents who are able to make their own decisions. RN Care Coordinators reviewed current MOST form with resident to ensure complete understanding of their advance directive desires. 3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur On 7/24/24, Assistant Director of Nursing completed education with Curana Providers, ensuring accuracy of progress notes and current MOST forms. On 7/29/24, Nursing Home Administrator completed education with RN Care Coordinator, Social Workers, Director of Transitional Services on advance directives, MOST forms, and documentation. Monthly for the next 12 months, RN Care Coordinator will audit the MOST forms and progress notes to ensure accuracy. Auditing tool will be turned into the Nursing Home Administrator and reported	

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F 578	Continued From page 4 status order into the computer. An interview was conducted on 7/11/2024 at 8:32 am with the Admission Nurse. The Admission Nurse stated she would ask residents about their code status and preferences on admission. The Admission Nurse reported after she verified the MOST form, she would enter the code status order in the chart. The Admission Nurse stated that if a MOST form indicated CPR with limited scope of treatment, she would enter the code status as full code and reported the facility does not enter limitations because the facility does not intubate or place residents on mechanical ventilation. The Admission Nurse stated the MOST form, active code status order, and code status on the progress note should have been consistent. NP #2 was unavailable for interview. The MD was unavailable for interview. An interview was conducted on 7/11/2024 at 11:15 am with Resident #32. Resident #32 stated he was able to remember someone, unsure of name, going over code status information on admission. Resident #32 expressed he wished to have CPR but he was not sure if he wanted any additional interventions because he was not sure what limitations were allowed. An interview was conducted on 7/11/2024 at 11:53 am with NP #2. NP #2 stated on admission, the SW reviewed and completed a MOST form with the resident. NP #2 stated when she conducted her visit with the resident upon admission, code status was reviewed with the resident and resident representative. NP #2	F 578	in quarterly QAPI. Monthly, Health Information will audit the code status and the MOST forms and verify in Advance Directive book to ensure accuracy. Health Information Coordinator will report audit in quarterly QAPI meeting. Quarterly, Interdisciplinary Team will review advance directives (code status and MOST form) and ensure Curana progress notes reflects MOST form. At least annually, Curana providers will review the MOST form with resident and/or resident representative. If a MOST form changes, a new form is completed, Curana providers will provide an updated copy of MOST form to RN Care Coordinator. 4) How the facility plans to monitor its performance to make sure that solutions are sustained; and include dates when corrective action will be completed. These corrective measures will be monitored by the RN Care Coordinators with oversight by the Administrator through the QAPI process to ensure the plan of correction is effective and that the deficiency cited remains corrected and/or in compliance with the regulatory requirements. The RN Care Coordinators will report on the corrective measures to the QAPI Committee which will evaluate for effectiveness for a minimum of 12 months. The Committee will make further recommendations to adjust the corrective	

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F 578	Continued From page 5 stated she was familiar with Resident #32 but was unaware that Resident #32 had a MOST form that indicated CPR with limited scope of treatment. NP #2 stated the facility would still enter in a full code order, but verbalized the progress note should not have said full scope of treatment if the resident wanted limited interventions. NP #2 stated she was not sure what limitations Resident #32 wanted. An interview was conducted on 7/11/2024 at 4:36 pm with the Director of Nursing (DON). The DON stated she thought nursing was responsible for completing the MOST forms and was unaware the SW had been completing them. The DON stated not all residents had a MOST form, but it was recommended. The DON stated code status was discussed on admission with nursing staff and the medical provider. The DON stated if a resident had elected CPR and limited scope of treatment on the MOST form, nursing staff would enter a full code order into the EHR. The DON stated limited scope of treatment included everything that would be performed in the facility because "we do not intubate or ventilate." The DON stated she was not aware of what limitations Resident #32 would want and stated that limitations should be written in under the instructions portion of the MOST form. The DON was unsure why the MD progress note dated 7/8/2024 revealed Resident #32 wished to receive a full scope of treatment. The DON stated the MOST form, code status order, and medical provider's progress note should indicate the resident's wishes. An interview was conducted on 7/11/2024 at 5:20 pm with the Administrator. The Administrator reported the SW was responsible for going over	F 578	measures as needed. The Committee is authorized to charter Performance Improvement Projects when most appropriate. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	

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F 578	Continued From page 6 code status wishes with the resident and/or resident representative upon admission and completed the MOST form at that time. The Administrator was not aware that Resident #32 had a MOST form that indicated CPR with limited scope of treatment, an order for full code in the EHR, and a physician progress note dated 7/8/2024 that revealed Resident #32 wished to have a full scope of treatment. The Administrator verbalized Resident #32's code status should be consistent throughout the medical record.	F 578		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to post cautionary safety signs that indicated the use of oxygen for 5 of 6 residents reviewed for respiratory care (Resident #79, #93, #136, #137 and #161). The findings included: 1) Resident #136 was admitted to the facility on 3/28/2024 with a diagnosis of shortness of breath. A review of a significant change Minimum Data Set (MDS) dated 7/1/2024 revealed Resident	F 695	Preparation and execution of this plan of correction in no way constitutes an admission or agreement by Abernethy Laurels of the truth of the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law, and because the facility has been threatened with termination from the Medicare and Medicaid programs if it fails to do so. The facility contends that it was in substantial compliance with all requirements on the	8/1/24

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#136 was cognitively intact with no behaviors and no rejections of care. Resident #136 was coded for oxygen therapy.

Review of a physician's order dated 7/8/2024 revealed an order for Resident #136 was to have oxygen administered at 2 liters per minute via nasal canula continuously.

An observation was conducted on 7/8/2024 at 12:02 pm. Resident #136 was observed lying in bed with oxygen being administered at a rate of 2 liters per minute. There was no oxygen signage outside of Resident #136's room or on the doorframe.

An observation was conducted on 7/8/2024 at 2:09 pm. There was no oxygen signage on the unit doors or outside of Resident #136's unit.

An observation was conducted on 7/9/2024 at 9:42 am. Resident #136 was observed lying in bed with oxygen being administered at a rate of 2 liters per minute. There was no oxygen signage outside of Resident #136's room or on the doorframe.

An observation was conducted on 7/10/2024 at 8:47 am. Resident #136 was observed lying in bed with oxygen being administered at a rate of 2 liters per minute. There was no oxygen signage outside of Resident #136's room or on the doorframe.

An interview was conducted on 7/10/2024 at 3:57 pm with Nurse #3. Nurse #3 stated when a resident was on oxygen there would be an order for oxygen in the computer, there would be an oxygen concentrator in their room, and an

F 695

survey date, and denies that any deficiency exists or existed or that any such plan is necessary. Neither the submission of such plan, nor anything contained in the plan, should be construed as an admission of any deficiency, or of any allegation contained in this survey report. The facility has not waived any of its rights to contest any of these allegations or any other allegation or action. This plan of correction serves as the allegation of substantial compliance.

Prefix Tag: F-695
It is the intent of this facility to post cautionary safety signs that indicate the use of oxygen for respiratory care. This Facility is a smoke free/tobacco free and fully sprinkled campus. There is “No Smoking” signage posted at the facility entrance.

1) How corrective action will be accomplished for those residents found to have been affected by the deficient practice

Facility is a smoke free, fully sprinkled campus and believed it be in compliance with oxygen signage. Non-Smoking and tobacco free signs have been posted at the front entrance door and outside of oxygen storage room notifying residents, employees, and visitors of non-smoking facility policy. However, on 7/18/24, additional “No Smoking” signage was added to the outside of each resident household and outside of the therapy

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emergency tank of oxygen on their wheelchair. Nurse #3 stated nurses had not put oxygen in use signs outside of resident's doors because it was a privacy issue.

An interview was conducted on 7/10/2024 at 4:24 pm with the Staff Development Coordinator (SDC). The SDC stated when a resident was on oxygen the nurse should verify the order on the Medication Administration Record (MAR). The SDC reported oxygen signage was not required in the facility except outside of the oxygen storage room.

An interview was conducted on 7/11/2024 at 4:03 pm with the Director of Nursing (DON). The DON stated when a resident is on oxygen the nursing staff changes the tubing weekly on night shift and there is an oxygen company that comes to the facility and cleans the filters. The DON reported the nurse on the hall is responsible for verifying the oxygen is being delivered at the correct rate based on the physician's order. The DON stated the facility had not used signage outside of resident rooms because the facility was "smoke free" and reported there was oxygen signage only outside of the oxygen storage rooms. The DON stated she was not aware there had to be signage outside of resident rooms.

2) Resident #161 was admitted to the facility on 6/28/2024 with a diagnosis of chronic respiratory failure with hypoxia.

Review of a physician's order dated 6/28/2024 revealed an order for Resident #161 was to have oxygen administered at 2 liters per minute via nasal canula continuously.

F 695

gym.

2) How the facility will identify other residents having the potential to be affected by the same deficient practice

On 7/18/24, additional signage was added to each resident's household and the outside entrance of the therapy gym to notify the public of no smoking and oxygen in use.

3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur

On 7/31/24 & 8/1/24, residents, employees and visitors were reminded that facility is a smoke free campus and re-educated on smoking policy and placement of additional signage.

Monthly, Director of Facility Management will verify that "No Smoking" signage is in place and observation of the facility grounds to ensure that visitors, staff, and residents are following the no smoking policy.

Semi-annually, Director of Facility Management will monitor and verify on the QAPI checklist that oxygen warning signs are posted in areas where oxygen is in use and where tanks are stored. This audit will be reported during quarterly QAPI meeting.

4) How the facility plans to monitor its performance to make sure that solutions

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A review of an admission Minimum Data Set (MDS) dated 7/4/2024 revealed Resident #161 was severely cognitively impaired and was coded for oxygen therapy.

An observation was conducted on 7/8/2024 at 11:49 am. Resident #161 was observed lying in bed with oxygen being administered at a rate of 2 liters per minute. There was no oxygen signage outside of Resident #136's room or on the doorframe.

An observation was conducted on 7/8/2024 at 2:09 pm. There was no oxygen signage on the unit doors or outside of Resident #161's unit.

An observation was conducted on 7/9/2024 at 9:24 am. Resident #161 was observed lying in bed with oxygen being administered at a rate of 2 liters per minute. There was no oxygen signage outside of Resident #161's room or on the doorframe.

An observation was conducted on 7/10/2024 at 8:44 am. Resident #161 was observed lying in bed with oxygen being administered at a rate of 2 liters per minute. There was no oxygen signage outside of Resident #161's room or on the doorframe.

An observation was conducted on 7/11/2024 at 10:27 am. Resident #161 was observed lying in bed with oxygen being administered at a rate of 2 liters per minute. There was no oxygen signage outside of Resident #161's room or on the doorframe.

An interview was conducted on 7/10/2024 at 3:57 pm with Nurse #3. Nurse #3 stated when a

F 695

are sustained; and include dates when corrective action will be completed.

These corrective measures will be monitored by the Director of Facility Management with oversight by the Administrator through the QAPI process to ensure the plan of correction is effective and that the deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Director of Facility Management will report on the corrective measures to the QAPI Committee which will evaluate for effectiveness for a minimum of 12 months. The Committee will make further recommendations to adjust the corrective measures as needed. The Committee is authorized to charter Performance Improvement Projects when most appropriate. The Administrator is responsible to see that recommendations are acted upon in a timely manner.

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resident was on oxygen there would be an order for oxygen in the computer, there would be an oxygen concentrator in their room, and an emergency tank of oxygen on their wheelchair. Nurse #3 stated nurses had not put oxygen in use signs outside of resident's doors because it was a privacy issue.

An interview was conducted on 7/10/2024 at 4:24 pm with the Staff Development Coordinator (SDC). The SDC stated when a resident was on oxygen the nurse should verify the order on the Medication Administration Record (MAR). The SDC reported oxygen signage was not required in the facility except outside of the oxygen storage room.

An interview was conducted on 7/11/2024 at 4:03 pm with the Director of Nursing (DON). The DON stated when a resident is on oxygen the nursing staff changes the tubing weekly on night shift and there is an oxygen company that comes to the facility and cleans the filters. The DON reported the nurse on the hall is responsible for verifying the oxygen is being delivered at the correct rate based on the physician's order. The DON stated the facility had not used signage outside of resident rooms because the facility was "smoke free" and reported there was oxygen signage only outside of the oxygen storage rooms. The DON stated she was not aware there had to be signage outside of resident rooms.

3. Resident #93 was admitted to the facility on 10/10/13 with diagnoses that included chronic respiratory failure.

Review of a physician order dated 04/20/24 read oxygen at 3 liters per minute continuously via

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nasal canula.

Review of the quarterly Minimum Data Set (MDS) dated 07/03/24 indicated Resident #93 was moderately cognitively impaired and required the use of oxygen.

An observation of Resident #93 was made on 07/09/24 at 9:27 AM. Resident #93 was resting in bed with oxygen being administered at 3 liters per minute via nasal canula. There was no cautionary sign noted to her door, door frame, or environment.

An observation of Resident #93 was made on 07/10/24 at 4:11 PM. Resident #93 was resting in bed with oxygen being administered at 3 liters per minute via nasal canula. There was no cautionary sign noted to her door, door frame, or environment.

An observation of Resident #93 was made on 07/11/24 at 11:28 AM. Resident #93 was resting in bed with oxygen being administered at 3 liters per minute via nasal canula. There was no cautionary sign noted to her door, door frame, or environment.

An interview was conducted with Nurse #5 on 07/11/24 at 1:46 PM who confirmed she was caring for Resident #93. Nurse #5 stated that she had been working at the facility since November 2023 and knew that oxygen tubing was assigned to be changed weekly on third shift. She stated that she thought it was third shift but just knew that it was not assigned to be completed on her shift. Nurse #5 stated that she checked Resident #93's oxygen concentrator throughout her shift to ensure that the correct dose of oxygen was being

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delivered. Nurse #5 stated that the facility utilized the red no smoking signs on doors and was then asked to go and observe Resident #93's room. Nurse #5 confirmed that there was no cautionary sign on the door or on the door frame or in the environment where Resident #93 resided, and oxygen was being delivered.

The Director of Nursing (DON) was interviewed on 07/11/24 at 4:03 PM. The DON stated that oxygen tubing, oxygen cannulas and nebulizer sets were changed out weekly by the nurse on third shift. The nurse was responsible for checking the dose routinely throughout the shift. The DON stated that the facility utilized cautionary no smoking signs on the oxygen storage rooms only and added that something was posted on the front door of the facility about the facility being tobacco free. The DON stated that she believed that the cautionary signs only needed to be where oxygen was stored but added they could add the cautionary signs where oxygen was administered as well.

4. Resident #137 was admitted to the facility on 03/15/24 with diagnoses that included chronic obstructive pulmonary disease and congestive heart failure.

Review of a physician order dated 06/13/24 read; oxygen via nasal cannula at 3 liters per minute continuously.

Review of a significant change Minimum Data Set (MDS) dated 06/19/24 revealed Resident #137 was cognitively intact, had shortness of breath with exertion and when lying flat and required the use of oxygen.

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An observation of Resident #137 was made on 07/08/24 at 3:18 PM. Resident #137 was resting in bed with oxygen being delivered at 3 liters per minute via nasal canula. There was no cautionary sign noted to her door, door frame, or environment.

An observation of Resident #137 was made on 07/09/24 at 9:20 AM. Resident #137 was resting in bed with oxygen being delivered at 3 liters per minute via nasal canula. There was no cautionary sign noted to her door, door frame, or environment.

An observation of Resident #137 was made on 07/10/24 at 9:15 AM. Resident #137 was resting in bed with oxygen being delivered at 3 liters per minute via nasal canula. There was no cautionary sign noted to her door, door frame, or environment.

An observation of Resident #137 was made on 07/11/24 at 1:47 PM. Resident #137 was resting in bed with oxygen being delivered at 3 liters per minute via nasal canula. There was no cautionary sign noted to her door, door frame, or environment.

An interview was conducted with Nurse #5 on 07/11/24 at 1:46 PM who confirmed she was caring for Resident #93. Nurse #5 stated that she had been working at the facility since November 2023 and knew that oxygen tubing was assigned to be changed weekly on third shift. She stated that she thought it was third shift but just knew that it was not assigned to be completed on her shift. Nurse #5 stated that she checked Resident #137's oxygen concentrator throughout her shift to ensure that the correct dose of oxygen was

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being delivered. Nurse #5 stated that the facility utilized the red no smoking signs on doors and was then asked to go and observe Resident #93's room. Nurse #5 confirmed that there was no cautionary sign on the door or on the door frame or in the environment where Resident #137 resided, and oxygen was being delivered.

The Director of Nursing (DON) was interviewed on 07/11/24 at 4:03 PM. The DON stated that oxygen tubing, oxygen cannulas and nebulizer sets were changed out weekly by the nurse on third shift. The nurse was responsible for checking the dose routinely throughout the shift. The DON stated that the facility utilized cautionary no smoking signs on the oxygen storage rooms only and added that something was posted on the front door of the facility about the facility being tobacco free. The DON stated that she believed that the cautionary signs only needed to be where oxygen was stored but added they could add the cautionary signs where oxygen was administered as well.

5. Resident #79 was admitted to the facility on 06/10/24 with diagnoses that included chronic obstructive pulmonary disease and respiratory failure.

The admission Minimum Data Set (MDS) assessment dated 06/17/24 revealed Resident #79's cognition was moderately impaired, and she wore supplemental oxygen.

A review of Resident #79's medical record revealed an order dated 07/08/24 for supplemental oxygen via nasal cannula at 2 liters per minute.

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F 695	Continued From page 15 An observation was made on 07/08/24 at 11:55 AM of Resident #79's room. In the room sat an oxygen concentrator with the nasal cannula lying on the Resident's bed. The concentrator was infusing oxygen at 2 liters per minute. Resident #79 was not in the room. There was no oxygen cautionary sign posted on the Resident's door or near her room to indicate oxygen was in use. An observation on 07/08/24 at 12:37 PM was made of Resident #79 sitting in the dining room wearing oxygen via nasal cannula delivered from the E-tank which was mounted on the back of the Resident's wheelchair. On 07/08/24 at 1:30 PM an observation and interview made with Resident #79 revealed the Resident was sitting in the doorway of her room but would not respond to simple questioning. Resident #79 wore oxygen via nasal cannula delivered at 2 liters via E-tank which was mounted on the back of her wheelchair. An interview was conducted with Nurse Aide (NA) #1 on 07/09/24 at 3:00 PM. The NA explained that the facility did not post cautionary signs for oxygen near the residents' door, but they did post the "no smoking signs" on the door where oxygen was stored. On 07/10/24 at 10:05 AM Resident #79 was sitting up in bed wearing oxygen via nasal cannula at 2 liters from an oxygen concentrator. There was no oxygen cautionary sign posted on or near the Resident's door. An interview was conducted with Nurse #2 on 07/10/24 at 10:24 AM. The Nurse explained that the facility did not post oxygen cautionary signs	F 695		

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F 695	Continued From page 16 on the residents' rooms, and they only posted the signs on the rooms where oxygen was stored. On 07/11/24 at 4:05 PM during an interview with the Director of Nursing (DON) she explained that the facility was a smoke free facility and did not allow smoking in the building or the grounds. The DON stated the cautionary signs were posted where oxygen was stored in the building, but the signs were not posted on the residents' doors where oxygen was in use. She indicated she thought having the "smoke free facility" sign posted on the front entrance was sufficient for the regulation.	F 695		