STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345342	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Elm Retirement and Nursing Centers	**1285 West A Street , Kannapolis, North Carolina, 28081**

(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
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 8/25/25 through 08/28/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1D4478-H1.	E0000		09/12/2025
F0000	INITIAL COMMENTS An onsite recertification and complaint investigation survey was conducted from 8/25/28 through 8/28/25. Event ID# 1D4478-H1. The following intake was investigated 2596813. One (1) of 1 complaint allegation did not result in deficiency.	F0000		09/12/2025
F0553 SS = D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care.	F0553	F0553 – Right to Participate in Planning Care (SS = D) The facility failed to afford the resident the right to participate in the care planning process for 2 of 2 residents reviewed for care plans (Resident #31, and Resident #21) 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 8/28/2025, Resident #31 and Resident #21 were invited to attend a scheduled for care plan meeting by the facility Social Worker scheduled for 8/29/2025. Resident #31 declined to meet with anyone except the Social Worker. Resident #21 was provided with the invitation to attend a care plan meeting scheduled for 8/29/2025. Resident #21 declined to attend the meeting, but did request to meet with the Director of Nursing. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All current long term care residents had the potential	09/22/2025

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 reverse for further 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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F0553 SS = D	Continued from page 1 §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and resident and staff interviews, the facility failed to afford the resident the right to participate in the care planning process for 2 of 2 residents reviewed for care plans (Resident #31, and Resident #21). The findings included: a. Resident #31 was admitted to the facility on 12/27/24 with diagnosis of hypertension, diabetes mellitus and respiratory failure. The quarterly Minimum Data Set (MDS) dated 8/18/25 revealed Resident #31 was cognitively intact. Resident #31's care plan was last updated on 7/2/25. An interview with Resident #31 on 8/25/25 at 11:45 AM was conducted and the Resident stated she had not been invited to a care plan meeting, and that there was not a family member that would have been invited instead of her. She stated that she would like to be invited to care plan meetings. An interview on 8/28/25 10:25 AM with the Social Worker (SW) was conducted. The SW indicated she had been employed since May 2024. She further indicated that the former Administrator never told her that care plan meetings were to be held for every resident on a quarterly basis. The SW stated she was trained to have care plan meetings only if the family or residents ask for one. The SW added the only care plan meetings conducted were for short-term rehabilitation residents only. The SW stated for the long-term Residents, care plan meetings were done by request, for change in condition, wounds or falls.	F0553	Continued from page 1 to be affected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 9/16/2025, the Social Worker and Minimum Data Set Nurse were educated by facility Administrator on the regulatory requirement that all residents (or their responsible parties if cognitively impaired) be invited to participate in quarterly, annual, and significant change care plan meetings. On 9/15/2025 a standardized Care Plan Invitation Letter template and phone call log were created by the Administrator to be implemented by facility Social Worker. Copies of invitations and documentation of verbal invitations are now required to be uploaded to the Electronic Medical Record by Medical Records staff, once completed by the facility Social Worker. Care plan meeting attendance sheets will be maintained by the Social Worker, with signatures of the resident and/or responsible party. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Director of Nursing (DON) will audit 5 resident records weekly for 8 weeks, then monthly for 3 months, to ensure documentation of care plan participation is present. Any identified non-compliance will result in staff re-education and corrective action. Results of audits will be presented by the DON or designee to the Quality Assurance and Performance Improvement (QAPI) Committee monthly, for three months for review and, if warranted, further action. The QAPI Committee will review compliance quarterly for 2 quarters to determine if ongoing monitoring is necessary. Completion Date: 09/22/2025	

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F0553 SS = D	Continued from page 2 An interview with the MDS Nurse on 8/28/25 at 10:25 AM was conducted. The MDS Nurse indicated that she was told by the former Administrator not to be involved with the Social Worker's task to invite the Resident or Responsible Party for a care plan meeting, so she did not intervene when the meetings were not being held. She further indicated that care plan updates were completed quarterly, as needed and annually. An interview with the Director of Nursing (DON) on 8/28/25 at 10:54 AM was conducted. The DON stated that care plan meetings were happening, but the invitation letters or phone calls to invite residents and/or Responsible Parties were not being made. The DON indicated that he dropped the ball in following up on the care plan meetings due to the position changes that had taken place. He explained he had stepped down as Administrator to the DON position until a new DON could be hired. The DON stated the care plan meeting process was that Residents that were alert and oriented were invited to attend and residents that were not alert and oriented had their Responsible Party invited. He further stated that the SW was very involved but did not know that she was supposed to conduct care plan meetings by inviting residents and/or the Responsible Party. He further stated that his expectation was that all Residents and Responsible Parties were invited to the care plan meetings and that documentation of the invitation be it phone call, letter or in person be uploaded into the medical record. b. Resident #21 was admitted to the facility on 09/26/24 with diagnoses of hypertension, chronic pain, muscle weakness, and lack of coordination. Review of Resident #21's quarterly Minimum Data Set dated 07/22/25 revealed the resident was cognitively intact. Resident #21's revised care plan was completed on 07/23/25. Review of Resident #21's medical record revealed no documentation that a care plan meeting had been completed with Resident #21 or the Resident Representative (RR). An interview conducted with Resident #21 on 8/27/25 at 11:17 AM revealed that she had not been invited to her care plan meetings. Resident #21 further revealed she would have attended the care plan meetings if she had been invited. An interview with Resident #21 on 8/25/25 at 2:05 PM	F0553		

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F0553 SS = D	Continued from page 3 was conducted and the Resident stated she had not been invited to a care plan meeting. The resident further revealed she would like to be invited to care plan meetings to discuss goals and plans of possible discharge. An interview on 8/28/25 10:25 AM with the Social Worker (SW) was conducted. The SW indicated she had been employed since May 2024. She further indicated that the former Administrator never told her that care plan meetings were to be held for every resident on a quarterly basis. The SW stated she was trained to have care plan meetings only if the family or residents ask for one. The SW stated for the long-term Residents, care plan meetings were done by request, for change in condition, wounds or falls. An interview with the MDS Nurse on 8/28/25 at 10:25 AM was conducted. The MDS Nurse indicated that she was educated to not be involved in care plan meetings per the prior Administrator. She further indicated that care plan meetings were conducted by the SW. An interview with the Director of Nursing (DON) on 8/28/25 at 10:54 AM was conducted. The DON stated that care plan meetings were happening, but the invitation letters or phone calls to invite residents and/or Responsible Parties were not being made. The DON indicated that he dropped the ball in following up on the care plan meetings due to the position changes that had taken place. He explained he had stepped down as Administrator to the DON position until a new DON could be hired. The DON stated the care plan meeting process was that Residents that were alert and oriented were invited to attend and residents that were not alert and oriented had their Responsible Party invited. He further stated that the SW was very involved but did not know that she was supposed to conduct care plan meetings by inviting residents and/or the Responsible Party. He further stated that his expectation was that all Residents and Responsible Parties were invited to the care plan meetings and that documentation of the invitation be it phone call, letter or in person be uploaded into the medical record.	F0553		
F0568 SS = B	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting	F0568	F0568 – Accounting and Records of Personal Funds (SS = B) The facility failed to provide personal fund statements to Resident #21. The Resident revealed she wanted to receive quarterly statements to know how much money she had to spend in her account. 1. Address how corrective action will be accomplished	09/22/2025

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F0568 SS = B	Continued from page 4 principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and resident and staff interviews, the facility failed to provide 1 of 3 residents with quarterly statements of their personal trust fund account managed by the facility (Resident #21). The findings included: Resident #21 was admitted to the facility on 09/26/24. Review of the quarterly Minimum Data Set (MDS) dated 7/22/25 indicated Resident #21 was cognitively intact. Interview with Resident #21 on 08/25/25 at 2:05 PM revealed she had not received any statements since admission but had money in a resident trust fund account. The Resident further revealed she wanted to receive quarterly statements to know how much money she had to spend in her account. Resident #21 stated no staff in the facility had ever discussed the resident's available funds with her. Interview with the Business Office Manager (BOM) on 08/27/25 at 1:20 PM revealed Resident #21 had not received any quarterly statements since admission. The BOM further revealed the facility had been mailing the quarterly statements to the resident's former home address and the resident should have been receiving them. The Business Office Manager indicated Resident #21 had money in a resident trust fund account that was managed by the facility. The BOM stated she was not sure how it was missed but would speak to Resident #21 and would start giving quarterly statements to Resident #21. An interview with the Director of Nursing (DON) on 08/28/25 at 12:30 PM revealed he was not aware Resident #21 had not received quarterly statements. The DON further revealed Resident #21 should receive quarterly statements and be knowledgeable of the money in her account.	F0568	Continued from page 4 for those residents found to have been affected by the deficient practice; On 8/27/2025 Resident #21 was provided with her current trust fund statement, and the Business Office Manager reviewed the account with Resident #21 to ensure understanding. The Business Office Manager identified that Resident #21 did not receive her statement because an incorrect address was listed in her statement profile. This was corrected on 8/27/2025. 2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 8/27/2025 the Business Office Manager conducted a facility-wide review of all residents with trust fund accounts to verify that quarterly statements were provided and delivered, and addresses were correct. There were no additional findings. 3.Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 9/15/2025, The Business Office Manager implemented a Quarterly Trust Fund Distribution Checklist that included verification of delivery (in-person handoff with signature or mailed to responsible party). The checklist will be maintained by the Business Office Manager. Beginning 9/15/2025, resident trust fund statements will be discussed during quarterly care plan meetings, ensuring residents are aware of their balances. 4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Administrator will review the Quarterly Trust Fund Distribution Checklist monthly for 6 months and randomly interview 5 residents per quarter for 2 quarters to ensure residents receive their trust fund statements. Results of the checklist reviews and resident	

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F0568 SS = B		F0568	Continued from page 5 interviews will be presented, by the Administrator, to the Quality Assurance and Performance Improvement (QAPI) Committee monthly, for 6 months for review and, if warranted, further action. Completion Date: 09/22/2025	
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff and Nurse Practitioner (NP) interviews, the facility failed to maintain safety for a severely cognitively impaired resident in a wheelchair when the Activities Director was assisting residents out the double doors at the front entrance of the facility to smoke. After assisting Resident #9 outside, the Activities Director failed to lock the brakes of Resident #9's wheelchair and Resident #9 rolled down the pavement in front of the facility approximately 31 feet and fell out of her wheelchair landing on her left side. Resident #9 sustained skin tears to the left elbow and left AKA (above the knee amputation) stump. Resident #9 also sustained abrasions to the chin, left cheek, lips, and the bridge of the nose with visible bleeding from the nostrils. This deficient practice occurred for 1 of 3 residents reviewed for accidents (Resident #9). The findings included: Resident #9 was admitted to the facility on 1/31/2025 with diagnoses that included muscle weakness, lack of coordination, tobacco use, chronic pain, anxiety and depression. The quarterly MDS dated 5/15/2025 revealed Resident #9 had severe cognitive impairment, rejected care daily, had bilateral lower extremity impairment and	F0689	F0689 – Free of Accident Hazards / Supervision / Devices (SS = D) The facility failed to maintain safety for a severely cognitively impaired resident in a wheelchair when the Activities Director was assisting residents out the double doors at the front entrance of the facility to smoke. After assisting Resident #9 outside, the Activities Director failed to lock the brakes of Resident #9's wheelchair and Resident #9 rolled down the pavement in front of the facility approximately thirty-one feet and fell out of her wheelchair landing on her left side. Resident #9 sustained skin tears to the left elbow and the left (fully healed) above the knee amputation stump. Resident #9 also sustained abrasions to the chin, left cheek, lips, and the bridge of the nose. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #9 was assessed immediately post-fall on 7/21/2025 by a staff Registered Nurse and Nurse Practitioner. Resident #9 was noted to have bled from forehead area. Resident #9 was monitored by nursing staff until Emergency Medical Services (911) arrived. Resident #9 was transferred by ambulance to the hospital where she was evaluated and diagnosed with a superficial head laceration. Upon re-admission to facility, Resident #9 was assessed for risk for falls, and her care plan was updated to include supervision when outside including smoking times, and to double-check to ensure her wheelchair brakes were locked. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All wheelchair bound residents have the potential to be affected.	09/22/2025

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F0689 SS = D	Continued from page 6 used a wheelchair. Resident #9 required substantial to maximal assistance with toileting hygiene, bathing, upper body dressing, rolling left to right and sitting to lying. Resident #9 was dependent on staff for lower body dressing and chair to bed to chair transfers. Resident #9 required supervision or touching assistance with propelling her wheelchair 50 feet with two turns and was dependent on staff for propelling her wheelchair 150 feet. Review of Resident #9's Focused Care Plan for Smoking dated 5/5/2025 indicated the resident would be assessed for smoking and required supervision at all times. The goal stated Resident #9 would abide by the smoking policy and would be supervised during smoking times through the review period. The interventions included to assess Resident #9's compliance with the smoking policy, staff to go out with Resident #9 at smoking intervals per facility protocol, smoking per facility protocol and supervision with all smoking activity. The Focused Care Plan for Risk of Falls related to bilateral above the knee amputation (AKA) dated 5/5/2025 indicated Resident #9 was at risk for falls due to weakness, deconditioning and decreased mobility. The goal stated Resident #9 would have reduced risk for fall injuries through staff assessment and interventions through the review period. The interventions included to anticipate resident needs, educate resident to allow staff to assist her when outside in her wheelchair for safety and to educate resident, family and caregivers about safety reminders and what to do if a fall occurs. An interview with the Activities Director was conducted on 8/26/25 at 3:06 PM. The Activities Director stated on 7/21/2025 she was assisting three (3) residents outside the front entrance of the building to smoke. She stated she positioned Resident #9 next to a garbage can outside the second set of double doors to avoid her wheelchair from rolling and quickly turned to assist the other two (2) residents and to avoid the door from hitting one of the residents. She stated when she turned back around, she observed Resident #9 laying on her left side with her head facing the parking lot yelling "help get me up" with blood observed around her nose. She notified Nurse #1 who assessed the resident and assisted her back to her wheelchair. She admitted she did not lock the brakes to Resident #9's wheelchair because everything happened so fast. She further stated she was in-serviced the following day by the Administrator (the current Director of Nursing). A progress note from Nurse #1 dated 7/21/2025 at 4:38	F0689	Continued from page 6 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 9/16/2025, All nursing, activity, and environmental service staff were in-serviced by the Staff Development Nurse on wheelchair safety protocols, emphasizing the requirement to lock brakes whenever residents are stationary, including during smoking or outdoor activities. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Director of Nursing or designee will conduct random supervision observation audits on 5 residents, twice weekly for 8 weeks to ensure compliance with brake locking and resident safety. Any identified noncompliance will result in staff re-education and corrective action. Results of the audits will be presented, by the Director of Nursing, to the Quality Assurance and Performance Improvement (QAPI) Committee monthly, for 2 months for review and, if warranted, further action. Completion Date: 09/22/2025	

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F0689 SS = D	Continued from page 7 PM revealed Resident #9 was found by staff outside of the facility lying on the sidewalk on her left side bleeding from the nose. In addition, the note indicated Resident #9 sustained skin tears to her left elbow, left above the knee amputation (AKA) stump, an abrasion to the left cheek, lips and nose. Nurse #1 indicated the bleeding from the resident's nose was controlled and the resident was assisted back to her wheelchair and to her bed. Nurse Practitioner #1 assessed the resident and placed orders for the resident to be transferred to the hospital for further evaluation. Emergency Medical Service (EMS) arrived at the facility on 7/21/2025 at 5:59 PM to transport Resident #9 to the hospital. On 8/27/2025 at 9:44 AM Nurse #1 was interviewed. She stated she was notified by a Nurse Assistant (NA) that Resident #9 fell outside. She stated that she observed Resident #9 laying on the pavement. She assessed Resident #9 and noted skin tears the left elbow and left above the knee (AKA) stump. Resident #9 was also observed to have blood coming from the nose. Pressure was applied to control the bleeding. Nurse #1 stated Resident #9 was crying in pain but could not recall where the pain was. Nurse #1 assisted Resident #9 back to her wheelchair and escorted the resident to her room for further assessment. The assessment found no additional injuries, resident cognition was at baseline and range of motion (ROM) was intact. Nurse Practitioner #1 was notified, assessed the resident and placed an order for the resident to be transferred to the hospital. Hospital Records with a service date of 7/21/2025 indicated Resident #9 had a Computed Tomography (CT) scan (medical imaging test that uses X-rays and a computer to create detailed cross-sectional pictures of the inside of the body) of the head, cervical spine (the upper section of the vertebral column consisting of the first seven (7) vertebrae located in the neck), and facial bones with no acute (sudden onset) fractures found. Nurse Practitioner #1 was interviewed on 8/27/2025 at 10:48 AM. She revealed Resident #9 was alert and oriented and allowed to smoke. She stated she could not recall the specific details about the incident. She stated she was concerned Resident #9 sustained a fracture of the nose due to the bleeding and injuries to the face. She further indicated she did not hesitate to place orders for Resident #9 to be transferred to the hospital and that staff handled the incident appropriately.	F0689		

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F0689 SS = D	Continued from page 8 An interview with Maintenance Employee #1 conducted on 8/27/2025 revealed the distance between where Resident #9 was placed outside of the double doors at the front of the facility to where she landed when she fell out of her wheelchair on 7/21/2025, measured approximately thirty-one (31) feet. Observation of the area where the incident occurred found the surface at the front entrance was level and flat, while the area to the left, leading toward the parking lot, had a subtle incline. An interview was conducted with the current DON (the Administrator when the incident occurred) on 8/28/2025 at 1:05 PM. He stated he was notified by Nurse #1 that Resident #9 fell outside of the building during a designated smoking time. He stated Nurse #1 informed him that Resident #9 was observed laying on the ground beside her wheelchair alert with some facial grimacing. He stated Resident #9 said she had pain in the facial area, and some blood was observed to her face. He stated Nurse Practitioner #1 was notified, assessed Resident #9 and recommended to send the resident to hospital for further evaluation and to rule out a facial fracture. He further revealed that no major injury resulted from the fall. He also indicated Resident #9 could propel herself, moving freely around the facility and could lock and unlock the brakes of her wheelchair. He stated prior to the fall that occurred on 7/21/2025, Resident #9 had no prior fall incidents, and that staff are only expected to lock the brakes of wheelchairs for residents who are fall risks. Lastly, he revealed residents had to use the front entrance to smoke instead of the designated smoking area in the back of the building because the doors in the back were being repaired and replaced.	F0689		
F0695 SS = D	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 record review, observations, and interviews with resident and staff, the facility failed to post	F0695	F0695 – Respiratory/Tracheostomy Care and Suctioning (SS = D) The facility failed to ensure that cautionary signage was posted for oxygen use near the entrance of Resident # 28's room. 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 8/28/2025, “Oxygen in Use” signs were posted at the entrance of Resident #28’s room. 2. Address how the facility will identify other residents having the potential to be affected by the	09/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345342	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Big Elm Retirement and Nursing Centers	**1285 West A Street , Kannapolis, North Carolina, 28081**

(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
F0695 SS = D	Continued from page 9 cautionary signs for oxygen in use for 1 of 3 residents reviewed for respiratory care (Resident #28). The findings included: Resident #28 was admitted to the facility 07/28/25 with diagnoses which included chronic obstructive pulmonary disease, chronic respiratory failure,. Review of Resident #28's admission Minimum Data Set (MDS) dated 08/03/25 revealed the resident was cognitively intact and was coded for oxygen use. A physician order for Resident #28 dated 08/15/25 read oxygen at 2 liters per minute via nasal canula to maintain oxygen above 90%. An observation conducted on 08/25/25 at 3:05 PM revealed there was no cautionary signage for oxygen use found anywhere near the entrance of Resident # 28's room. Resident #28 was observed wearing oxygen via nasal cannula at 2 liters per minute (LPM). The oxygen concentrator was observed in Resident #28's room. An observation conducted on 08/27/25 at 9:25 AM revealed there was no cautionary signage for oxygen use found anywhere near the entrance of Resident # 28's room. Resident #28 was observed wearing oxygen via nasal cannula at 2 liters per minute (LPM). The oxygen concentrator was observed in Resident # 28's room. An interview conducted with Unit Manager #1 on 08/28/25 at 11:00 AM revealed she was not aware Resident #24, Resident #23, and Resident #28 did not have an oxygen sign posted outside their rooms but should have. UM #1 stated she and nursing were responsible for hanging cautionary oxygen signs. An interview conducted with the Director of Nursing (DON) dated 08/28/25 at 12:30 PM revealed the facility had recently had renovations and the signs were not put back up. The DON stated he was not aware the signs were not posted, and cautionary oxygen signs were expected to be posted for any residents with oxygen orders.	F0695	Continued from page 9 same deficient practice; All residents had the potential to be affected. A facility-wide audit was completed by the unit manager on 8/28/25 of all residents with oxygen orders to ensure proper signage was present. Any missing signage was immediately corrected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Nursing staff were educated on the requirement to maintain cautionary oxygen signage for any resident on oxygen therapy by the Staff Development Nurse on 9/15/25. Nursing staff that were not in attendance for the in-person in-service will receive education at the beginning of their next tour of duty. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; · The Director of Nursing or designee will audit all resident rooms with oxygen use 3 times weekly for four weeks, then weekly for eight weeks to ensure signage is posted. · Results of the audits will be presented, by the Director of Nursing, to the Quality Assurance and Performance Improvement (QAPI) Committee monthly, for 3 months for review and, if warranted, further action. Completion Date: 09/22/2025 Administrator's Attestation The facility respectfully submits this Plan of Correction. We allege compliance on the dates noted above. We understand our obligation to maintain substantial compliance with all federal requirements and recognize that systemic monitoring and corrective action are necessary to ensure ongoing compliance.	