STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345048	A. BUILDING _____ B. WING _____	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN RIDGE HEALTH AND REHAB	611 OLD US HIGHWAY 70 EAST BLACK MOUNTAIN, NC 28711

(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 survey was conducted on 05/27/25 through 05/30/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 77EE11.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted from 05/27/25 through 05/30/25. Event ID #77EE11.	F 000		
F 605 SS=D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2), 483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints	F 605		6/17/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/17/2025

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F 605	Continued From page 1 imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 605		

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F 605	Continued From page 2 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to ensure an as needed (PRN) psychotropic medication, Lorazepam (medication used to relieve anxiety), had a stop date of 14 days for 1 or 5 residents (Resident #7) reviewed for unnecessary medications. The findings included: Resident #7 was readmitted to the facility on	F 605	1. Resident #7s order for as needed Lorazepam was discontinued on 6/16/2025. 2. Residents with as needed psychotropic medication orders have the potential to be affected by this alleged deficient practice. The Director of Nursing has reviewed residents with as needed psychotropic medications to validate a 14-day stop date is included. This was	

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F 605	Continued From page 3 05/04/25 with diagnoses that included anxiety and depression. A physician's order entered by Nurse #1 on 05/04/25 at 4:11 PM for Resident #7 read, Lorazepam 0.5 milligrams (mg) every 12 hours as needed (PRN) for anxiety. There was no stop date. Resident #7's quarterly Minimum Data Set dated 05/12/25 revealed she was cognitively intact, displayed no behaviors or rejection of care and did not receive antianxiety medication. Review of Resident #7's May 2025 medication administration record (MAR) revealed the Lorazepam 0.5 mg every 12 hours PRN for anxiety remained an active order. There were no doses administered. During an interview on 05/29/25 at 2:34 PM, the Director of Nursing (DON) revealed recently, most of their providers had started entering their own orders and weren't always good about putting stop dates for medications when indicated but they did have standing orders that a medication could be discontinued after 60 days if not used. The DON explained Resident #7's order for PRN Lorazepam was verified with the on-call provider upon her return from the hospital on 05/04/25 and the order should have indicated a stop date of 14-days. The DON stated she was confident that the Consulting Pharmacist would have caught that Resident #7's physician order for PRN Lorazepam did not have a stop date when he conducted his monthly medication review for May 2025. A phone attempt for an interview with Nurse #1	F 605	completed on 6/2/2025. All concerns identified were addressed at time of discovery. 3. The Director of Nursing or Staff Development Coordinator has educated Licensed Nurses and providers on the requirement of a 14 day stop date for any psychotropic medications ordered as needed. This education was initiated on 6/2/2025 and completed by 6/16/2025. Any Licensed Nurse or Medical Provider not receiving this education by this date will receive prior to next scheduled shift. This information will be presented in new Licensed Nurse and medical provider orientation. The facility does not utilize agency staff. 4. The Director of Nursing, Assistant Director of Nursing, or RN Supervisor will monitor as needed psychotropic medication orders for the required 14 day stop date weekly for 3 months. Results of monitoring will be presented by the Director of Nursing to the Quality Assurance and Performance Improvement Committee that includes the Medical Director, Administrator, Director of Nursing, Infection Preventionist, Activity Director, Environmental Services Director, Social Services Director, and Minimum Data Set Coordinator for a period of 3 months. Any concerns identified will be addressed at time of discovery. 5. Date of Compliance 6/17/2025.	

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F 605	Continued From page 4 on 05/30/25 at 9:10 AM was unsuccessful. During an interview on 5/30/25 at 12:03 PM, the Administrator stated Resident #7's physician order for PRN Lorazepam should have had a stop date of 14 days. He stated it would have been an opportunity for the admitting nurse to have questioned the provider when orders were being verified.	F 605		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.	F 641		6/17/25

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F 641	Continued From page 5 §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the areas of hospice care, and PASRR for 3 of 4 residents (Resident #25, Resident #31, and Resident #36) whose MDS were reviewed. The findings included: 1. Resident #25 was admitted to the facility on 10/28/14 with diabetes mellitus. A Hospice Initial Certification dated 2/3/25 indicated Resident #25 was certified as eligible for hospice care based on her diagnosis and current condition, and that she was expected to have a limited life expectancy of 6 months of less if the terminal illness ran its course. The quarterly Minimum Data Set (MDS) assessment dated 5/8/25 indicated Resident #25 did not receive hospice care while a resident at the facility. An interview with the MDS Coordinator on 5/29/25 at 8:38 AM revealed Resident #25 was on hospice care, and that she completed Resident #25's quarterly MDS dated 5/8/25. The MDS Coordinator stated she was not sure how she missed hospice care on Resident #25's MDS. She stated that it was an oversight and that Resident #25's quarterly MDS should have reflected that she received hospice care. An interview with the Administrator on 5/30/25 at	F 641	1. Resident #25□s section O of the Minimum Data Set with an Assessment Reference Date of 5/8/2025 was modified on 5/29/2025 to reflect hospice services being received. Resident #31□s section A of the Minimum Data Set with an Assessment Reference Date of 4/8/2025 was modified on 5/29/2025. Resident #36□s section A of the Minimum Data Set with an Assessment Reference Date of 4/8/2025 was modified on 5/29/2025. 2. Resident receiving hospice services and resident with level II PASRR□s have the potential to be affected by this alleged deficient practice. The corporate Director of Quality and Reimbursement has reviewed the most recently completed Minimum Data Sets for current facility residents receiving hospice services and with level II PASRR□s to validate accurate coding. This was completed on 6/11/2025. No other concerns were identified. 3. The corporate Director of Quality and Reimbursement has educated the Minimum Data Set coordinator on accurate coding of section O, specific to hospice services and section A, specific to level II PASRR. This education was completed on 6/11/2025. This information will be presented in new hire Minimum Data Set coordinator orientation. The facility does not utilize agency staff. 4. The Administrator will monitor section O and section A of completed Minimum	

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F 641	Continued From page 6 12:03 PM revealed the MDS should have been coded correctly. 2. Resident #31 was admitted to the facility on 12/06/23 with diagnoses that included schizoaffective disorder-depressive type, bipolar disorder and Post-Traumatic Stress Disorder (PTSD). A PASRR Level II determination notification letter dated 01/02/25 revealed Resident #31 had a Level II PASRR with no expiration date. The significant change Minimum Data Set (MDS) assessment dated 04/01/25 revealed Resident #31 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. During an interview on 05/29/25 at 8:38 AM, the MDS Coordinator confirmed Resident #31 had a Level II PASRR and the MDS assessment dated 04/01/25 was completed by another MDS Coordinator who was no longer employed. The MDS coordinator stated was not sure how it was missed and the MDS assessment should have reflected Resident #31 had a Level II PASRR. An interview with the Administrator on 05/30/25 at 12:03 PM revealed he expected MDS assessments to be coded correctly. 3. Resident #36 was admitted to the facility on 01/09/24 with diagnoses that included bipolar disorder, delusional disorder, anxiety disorder, and major depressive disorder. A PASRR Level II determination notification letter	F 641	Data Sets for residents receiving hospice services and residents with level II PASSR□s to validate accuracy of coding weekly for 4 weeks then monthly for 2 months. Results of the monitoring will be presented by the Administrator to the Quality Assurance and Performance Improvement Committee that includes the Medical Director, Administrator, Director of Nursing, Infection Preventionist, Activity Director, Environmental Services Director, Social Services Director, and Minimum Data Set Coordinator for a period of 3 months. All concerns identified will be addressed at time of discovery. 5. Date of Compliance 6/17/2025.	

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F 641	Continued From page 7 dated 07/25/24 revealed Resident #36 had a Level II PASRR with no expiration date. The annual Minimum Data Set (MDS) assessment dated 11/11/24 revealed Resident #36 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. During an interview on 05/29/25 at 8:38 AM, the MDS Coordinator confirmed Resident #36 had a Level II PASRR and the MDS assessment dated 11/11/24 was completed by another MDS Coordinator who was no longer employed. The MDS coordinator stated was not sure how it was missed and the MDS assessment should have reflected Resident #36 had a Level II PASRR. An interview with the Administrator on 05/30/25 at 12:03 PM revealed he expected MDS assessments to be coded correctly.	F 641		
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 record review, observations, resident and staff interviews, the facility failed to post	F 695	1. Residents #14, #74, #28, #7 and #51 have Oxygen in use signage on their room	6/17/25

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F 695	Continued From page 8 cautionary and safety signage outside residents' rooms that indicated the use of oxygen for 5 of 5 residents reviewed for respiratory care (Resident #14, Resident #74, Resident #28, Resident #7 and Resident #51). The findings included: 1. Resident #14 was admitted to the facility on 3/25/25 with diagnoses that included chronic obstructive pulmonary disease, and acute respiratory failure with hypoxia (a condition in which there is an inadequate supply of oxygen to the body's tissues). A review of Resident #14's physician orders indicated an order dated 4/25/25 for oxygen to be administered continuously via nasal cannula at 3 liters per minute every shift. The quarterly Minimum Data Set assessment dated 5/2/25 Resident #14 was cognitively intact and received oxygen therapy while a resident at the facility. An observation on 5/27/25 at 10:17 AM revealed Resident #14 sitting in her wheelchair by her bed with oxygen being administered by an oxygen concentrator. There was no signage posted outside Resident #14's room indicating supplemental oxygen was in use. An observation of Resident #14 on 5/28/25 at 12:13 PM revealed her sitting up in her recliner while eating her lunch meal. Resident #14 received oxygen via nasal cannula which was connected to an oxygen concentrator. There was no cautionary or safety signage posted outside her room indicating supplemental oxygen was in	F 695	door. All signage was placed on 5/29/2025. 2. Residents receiving Oxygen have the potential to be affected by this alleged deficient practice. The Director of Nursing has observed current residents receiving Oxygen to confirm required signage is present on their room door. This was completed on 6/10/2025. All concerns identified were addressed at time of discovery. 3. The Nurse Managers educated Licensed Nurses on the newly updated Oxygen Administration Policy, that states; Oxygen warning signs must be placed on the door of the resident□s room where Oxygen is in use. This education was initiated on 5/29/2025 and completed by 6/16/2025. Any Licensed Nurse not receiving the education by this date will receive prior to next scheduled shift. The facility does not utilize agency staff. 4. The facility department managers will monitor residents receiving Oxygen for the presence of signage weekly for 3 months. Results of the monitoring will be reviewed by the Administrator and presented by the Administrator to the Quality Assurance and Performance Improvement Committee that includes the Medical Director, Administrator, Director of Nursing, Infection Preventionist, Activity Director, Environmental Services Director, Social Services Director, and Minimum Data Set Coordinator for a period of 3 months. All concerns identified will be addressed at time of discovery. 5. Date of Compliance is 6/17/2025.	

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F 695	Continued From page 9	F 695		

use.

An interview with Nurse #2 on 5/29/25 at 10:52 AM revealed Resident #14 had always used oxygen, but she was not aware of any oxygen use signage that the facility used for residents receiving supplemental oxygen.

An interview with the Director of Nursing (DON) on 5/29/25 at 11:18 AM revealed the facility didn't put oxygen signage by the door of each resident receiving oxygen, and they hadn't done this in years. The DON stated that she would have to look for the reason why they had not been using them, and that she would need to pull the facility's policy on oxygen use.

A follow-up interview with the DON on 5/29/25 at 12:00 PM revealed she reviewed the facility's policy which stated that because the facility was located on a smoke-free campus, they only needed to place signage at major entry points of the facility, and that this was what they had been doing.

An interview with the Administrator on 5/29/25 at 1:21 PM revealed that they had received conflicting information regarding putting up oxygen signage and whether it was required only at entry points or on each resident room door. The Administrator stated that they would change the facility's policy and put the oxygen signs up in each resident room after he reviewed the current federal guidelines.

2. Resident #74 was admitted to the facility on 4/24/25 with diagnoses that included chronic obstructive pulmonary disease. She was re-admitted to the facility on 5/23/25 for acute

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F 695	Continued From page 10	F 695		

respiratory failure with hypoxia (a condition in which there is an inadequate supply of oxygen to the body's tissues), and pulmonary embolism (a condition in which one or more arteries in the lungs become blocked by a blood clot).

The admission Minimum Data Set assessment dated 4/30/25 indicated Resident #74 was cognitively intact, but she did not receive oxygen therapy while a resident at the facility.

A review of Resident #74's physician orders indicated an order dated 5/28/25 for oxygen to be administered at 2 liters per minute as needed via nasal cannula to maintain oxygen saturation above 90%.

An observation and interview with Resident #74 on 5/27/25 at 11:02 AM revealed she only started receiving oxygen when she was at the hospital where she had a blood clot in her lungs. Resident #74 was observed receiving oxygen via nasal cannula which was connected to an oxygen concentrator and was running at 2 liters per minute. There was no oxygen in use signage visible outside her room by the door.

An observation of Resident #74 on 5/28/25 at 12:11 PM revealed her sitting up in her wheelchair while being assisted by a staff member with her lunch tray set-up. Resident #74 received oxygen via nasal cannula which was connected to an oxygen tank at the back of her wheelchair. There was no cautionary or safety signage posted outside her room indicating supplemental oxygen was in use.

An interview with Nurse #2 on 5/29/25 at 10:52 AM revealed Resident #74 only started using

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F 695	Continued From page 11	F 695		

oxygen after she got back from the hospital wherein she had blood clots in her lungs. Nurse #2 stated that she was not aware of any oxygen use signage that the facility used for residents receiving supplemental oxygen.

An interview with the Director of Nursing (DON) on 5/29/25 at 11:18 AM revealed the facility didn't put oxygen signage by the door of each resident receiving oxygen, and they hadn't done this in years. The DON stated that she would have to look for the reason why they had not been using them, and that she would need to pull the facility's policy on oxygen use.

A follow-up interview with the DON on 5/29/25 at 12:00 PM revealed she reviewed the facility's policy which stated that because the facility was located on a smoke-free campus, they only needed to place signage at major entry points of the facility, and that this was what they had been doing.

An interview with the Administrator on 5/29/25 at 1:21 PM revealed that they had received conflicting information regarding putting up oxygen signage and whether it was required only at entry points or on each resident room door. The Administrator stated that they would change the facility's policy and put the oxygen signs up in each resident room after he reviewed the current federal guidelines.

3. Resident #28 was admitted to the facility on 2/20/25 with diagnoses that included pneumonia, heart failure and acute kidney failure.

A review of Resident #28's physician orders revealed an order dated 5/15/25 for oxygen to be

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	345048	A. BUILDING _____ B. WING _____	05/30/2025

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MOUNTAIN RIDGE HEALTH AND REHAB	611 OLD US HIGHWAY 70 EAST BLACK MOUNTAIN, NC 28711

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administered continuously every day and night shift via nasal cannula at 2-3 liters per minute to keep oxygen saturation greater than 90%.

A review of the Quarterly Minimum Data Set (MDS) dated 4/11/25 revealed Resident #28 was severely cognitively impaired and was coded for oxygen use.

An observation on 5/27/25 at 10:19 AM revealed Resident #28 sitting in her wheelchair by her bed with oxygen being administered via nasal cannula by an oxygen concentrator. There was no cautionary or safety signage posted outside her room indicating supplemental oxygen was in use.

An observation on 5/28/25 at 8:34 AM revealed Resident #28 sitting in her wheelchair by her bed with oxygen being administered via nasal cannula by an oxygen concentrator. There was no cautionary or safety signage posted outside her room indicating supplemental oxygen was in use.

During an interview with Nurse #3 on 5/29/25 at 2:12 PM it was revealed nursing staff were responsible for placing oxygen signage on the resident's door upon admission or if oxygen was a new order. She did not know why Resident #28 did not have signage on her door.

An interview on 5/29/25 at 11:18 AM with the Director of Nursing (DON) revealed the facility did not put signage on the individual doors of residents receiving oxygen. She indicated she would look up the facility policy on oxygen signage use.

During a follow-up interview with the DON on 5/29/25 at 12:00 PM she revealed the facility's

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policy stated that because the facility was a smoke-free campus oxygen signage only needed to be placed at the major entry points of the facility.

An interview with the Administrator on 5/29/25 at 1:21 PM revealed he had received conflicting information regarding oxygen signage and whether it was required only at entry points or on the door of each resident receiving oxygen. The Administrator indicated they would amend their policy and place oxygen signage on the door of each resident receiving oxygen and educate staff on the amended policy.

4. Resident #7 was readmitted to the facility on 05/04/25 with diagnoses that included respiratory failure and chronic obstructive pulmonary disease (COPD, difficulty breathing).

The quarterly Minimum Data Set (MDS) assessment dated 05/12/25 revealed Resident #7 had intact cognition and received oxygen therapy while a resident at the facility.

A physician's order dated 05/12/25 for Resident #7 revealed she was to receive continuous oxygen administered via nasal canula at 2 liters per minute (LPM) every shift.

An observation on 05/27/25 at 2:08 PM revealed Resident #7 lying in bed receiving supplemental oxygen via nasal cannula with the flow rate on the oxygen concentrator set at 2 LPM. There was no cautionary signage posted on the door, doorframe or in Resident #7's room to indicate oxygen was in use.

A subsequent observation conducted on 05/28/25

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at 3:43 PM revealed Resident #7 lying in bed receiving supplemental oxygen via nasal cannula with the oxygen concentrator set at 2 LPM. There was no cautionary signage posted on the door or doorframe of Resident #7's room to indicate oxygen was in use.

During an interview on 05/29/25 at 10:11 AM, Nurse #4 confirmed Resident #7 received continuous oxygen. Nurse #4 stated the facility did not use oxygen cautionary signage for residents receiving supplemental oxygen.

During an interview on 05/29/25 at 11:18 AM, the Director of Nursing (DON) revealed the facility didn't put oxygen cautionary signage on or by the room doors of residents receiving supplemental oxygen and hadn't done so in years. The DON stated she wasn't sure why the facility did not use oxygen cautionary signage and would check the facility's policy for oxygen use.

During a follow-up interview on 05/29/25 at 12:00 PM, the DON stated the facility's policy for oxygen use stated that because the facility was a smoke-free campus, they only needed to place cautionary signage at the major entry points of the facility which was what they had been doing.

During an interview on 05/29/25 at 1:21 PM, the Administrator stated they had received conflicting information regarding oxygen cautionary signage and whether it was required only at entry points to the facility or on the room doors of the residents receiving supplemental oxygen. The Administrator state they would change the facility's policy to reflect placing oxygen signage on the room doors of residents receiving supplemental oxygen and would educate staff on

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the policy change.

5. Resident #51 was admitted to the facility on 07/11/24 with diagnoses that included chronic respiratory failure, emphysema (lung condition that causes shortness of breath) and chronic obstructive pulmonary disease (COPD, difficulty breathing).

The quarterly Minimum Data Set (MDS) assessment dated 03/12/25 revealed Resident #51 had intact cognition and received oxygen therapy while a resident at the facility.

A physician's order dated 03/12/25 for Resident #51 revealed he was to receive continuous oxygen administered via nasal canula at 2 liters per minute (LPM) every shift.

During an observation and interview on 05/27/25 at 10:26 AM, Resident #51 was sitting up in bed receiving supplemental oxygen via nasal cannula connected to an oxygen concentrator set at 2 LPM. Resident #51 revealed he had received supplemental oxygen at 2 LPM for quite some time, which helped him with his breathing. There was no cautionary signage posted on the door or doorframe of Resident #51's room to indicate oxygen was in use.

An observation conducted on 05/28/25 at 3:52 revealed Resident #51 sitting in his wheelchair receiving supplemental oxygen via nasal cannula that was connected to a portable, oxygen cylinder fastened to the back of his wheelchair. There was no cautionary signage posted on the door or doorframe of Resident #51's room to indicate oxygen was in use.

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F 695	Continued From page 16 An observation conducted on 05/29/25 at 10:58 AM revealed Resident #51 lying in bed with the head of the bed slightly elevated and sleeping soundly. He was receiving supplemental oxygen via nasal cannula connected to an oxygen concentrator set at 2 LPM. There was no cautionary signage posted on the door or doorframe of Resident #51's room to indicate oxygen was in use. During an interview on 05/29/25 at 11:18 AM, the Director of Nursing (DON) revealed the facility didn't put oxygen cautionary signage on or by the room doors of residents receiving supplemental oxygen and hadn't done so in years. The DON stated she wasn't sure why the facility did not use oxygen cautionary signage and would check the facility's policy for oxygen use. During a follow-up interview on 05/29/25 at 12:00 PM, the DON stated the facility's policy for oxygen use stated that because the facility was a smoke-free campus, they only needed to place cautionary signage at the major entry points of the facility which was what they had been doing. During an interview on 05/29/25 at 1:21 PM, the Administrator stated they had received conflicting information regarding oxygen cautionary signage and whether it was required only at entry points to the facility or on the room doors of the residents receiving supplemental oxygen. The Administrator state they would change the facility's policy to reflect placing oxygen signage on the room doors of residents receiving supplemental oxygen and would educate staff on the policy change.	F 695		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		6/17/25

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F 812	Continued From page 17 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to discard food with signs of spoilage in 1 of 1 walk-in cooler and date open food items and food ready for use in 1 of 1 walk-in cooler. This practice had the potential to affect food served to residents. The findings included: An observation of the walk-in cooler with the Dietary Manager on 5/27/25 at 9:12 AM revealed the following: a. An opened 32-ounce container of sour cream with no open date.	F 812	1. No residents cited. The identified container of sour cream and the two (2) cracked eggs were discarded at time of discovery. 2. Residents in the facility have the potential to be affected by this alleged deficient practice. The Registered Dietician performed a visual observation of the facility kitchen to confirm all opened items were dated with open date and items not suitable for use were discarded. This was completed on 5/29/2025. All concerns identified were addressed at time of discovery. 3. The Registered Dietician has educated the Dietary department	

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F 812	Continued From page 18 b. An undated egg flat containing 17 eggs. Two of the eggs were cracked on top with shiny clear material noted around the cracks. An interview on 5/29/25 at 1:48 PM with the Dietary Manager revealed the facility's policy stated to put a date on any food item when it was opened, and that any spoiled food should be discarded immediately. She indicated she and the cook were responsible for checking dates on items in the coolers and freezer daily. The Dietary Manager revealed the sour cream container and egg flat should have had an open date, and the broken eggs should have been thrown out. An interview on 5/30/25 at 12:05 PM with the Administrator revealed the Dietary Manager and cook were responsible for labeling and dating items in the kitchen. He expected all food items to be labeled, dated and for the dietary staff to check the coolers and discard any food items that were undated or had visible signs of spoilage.	F 812	employees on the proper storage of food items, including the discarding of cracked eggs and dating of opened products. This education was initiated on 6/5/2025 and completed by 6/16/2025. Any Dietary department employees not receiving this education by this date will receive prior to next scheduled shift. This information will be presented in Dietary new hire orientation. The facility does not utilize agency staff. 4. The Certified Dietary Manager will monitor kitchen food storage for proper dating of open items & discarding of cracked eggs 3 times per week for 4 weeks then weekly for 2 months. Results of the monitoring will be presented by the Certified Dietary Manager to the Quality Assurance and Performance Improvement Committee that includes the Medical Director, Administrator, Director of Nursing, Infection Preventionist, Activity Director, Environmental Services Director, Social Services Director, and Minimum Data Set Coordinator by the Administrator for a period of 3 months. All concerns identified will be addressed at time of discovery. 5. Date of Compliance 6/17/2025.	