STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	170090	A. BUILDING: _____ B. WING _____	07/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COTTAGES OF SWANSBORO-COTTAGE IV	127 DOLPHIN BAY ESTATES CEDAR POINT, NC 28584

(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) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section and the Onslow Department of Social Services conducted an annual survey on July 23, 2021.	C 000		
C 078	10A NCAC 13G .0315(a)(5) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the facility was free of obstructions and hazards as evidenced by 6 of 6 oxygen tanks being stored in an unsecured manner on the floor without a stand or storage rack to prevent tipping within a resident's room which were stored behind a resident's door. The findings are: Observation of a Resident #1's room on 07/23/21 at 9:21am revealed: -There were four small oxygen tanks stored on the floor behind the door leading into the resident's room. -There were two small oxygen tanks stored on the floor in an unsecured manner in padded carrying cases. -One of small oxygen tanks in the padded	C 078		

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carrying cases was upright and the other small tank was laying flat on the resident's floor.
-Four of the small oxygen tanks had blue unbroken seals.
-There was an oxygen concentrator that was operating next to the six unsecured oxygen tanks behind the resident's door.

Review of Resident #1's FL-2 dated 06/24/21 revealed:
-Diagnoses included encounter for surgical aftercare following surgery on the digestive system, anemia, anorexia, moderate protein-calorie malnutrition, dementia, chronic atrial fibrillation, pleural effusion, osteoarthritis, and chronic kidney disease stage 3A.
-She was intermittently disoriented.
-She was non-ambulatory.
-There was an order for continuous oxygen at 2 liters.

Interview with the registered nurse (RN) Supervisor on 07/23/21 at 9:28am revealed:
-Resident #1 just transitioned to a new Durable Medical Equipment company (DME) for her oxygen delivery.
-The DME company would deliver oxygen supplies to Resident #1's room.
-She was not sure the date of Resident #1's last delivery of oxygen.
-She was not aware there were 6 oxygen tanks behind the Resident#1's door.

Interview with a personal care aide on 07/23/21 at 10:15am revealed:
-During the week of 07/19/21, she had worked Wednesday, 07/21/21, and today, 07/23/21.
-She had seen Resident #1's oxygen canisters stored in her room prior to the week of 07/19/21 and not in a storage rack but could not recall for

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C 078	Continued From page 2	C 078		

how long and how many.
-She had not moved them because she was not sure what the facility's oxygen storage policy was.
-There was resident safety risk, oxygen was flammable gas and the canisters were next to a "hot" oxygen concentrator which was operating continuously.

Interview with the medication aide/Supervisor in charge (MA/SIC) on 07/23/21 at 3:04pm revealed:
-She worked 5 days per week at the facility.
-She was not aware of the 6 oxygen canisters stored on Resident #1's floor.
-She was not aware of what the facility's oxygen storage policy was.
-She knew resident's oxygen supplies were typically stored at facility's main office.
-She knew oxygen canisters should be secured in a holder and a cool area.
-If oxygen canisters were unsecured, they could tip over and explode.

Interview with Resident #1's family member on 07/23/21 at 4:39pm revealed:
-He came to visit Resident #1 every week.
-The oxygen canisters had been sitting in the resident's room behind her door.
-He could not recall how many canisters were in the room or how long the canisters had been stored in the resident's room.
-He knew he had brought in two from the previous DME company and there were 4 new oxygen canisters from the new DME company.

Telephone interview with a representative from the facility's contracted DME provider on 07/23/21 at 2:22pm revealed:
-When the DME company delivered the oxygen canisters to the facility they called the facility's

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main office to notify them of the delivery of oxygen canisters.
-The oxygen canisters were delivered directly to the resident's room.
-According to their computer database Resident #1's last oxygen delivery was 05/18/21.
-The delivery included 4 m-6 small tanks, 1 bag tank, and 1 E cylinder rolling cart.
-He did not complete the delivery of Resident #1's oxygen supplies on 05/18/21.
-The unsecured oxygen canisters were "suspectable" to explode.
-The resident's door could swing open and cause the oxygen canisters to tip over.
-Oxygen canister should be stored in a crate or stand to stabilize them and prevent tipping if stored upright.
-If an oxygen canister tipped over it could injure someone by flying across the room due to pressure build-up or explode.
-When an oxygen tank was full it held approximately 2,000 pounds of pressure.
-The explosion would be caused when the 2,000 pounds of pressure tried to go through the 1-inch hole and could fly off like a rocket.

Second interview with the RN Supervisor on 07/23/21 at 3:58pm revealed:
-She tried to make rounds to all five houses onsite daily.
-She would go to the houses on as needed basis.
-She estimated Resident #1's oxygen canister were delivered to the facility around 05/18/21.
-On 05/16/21 or 05/17/21 she signed the agreement with Resident #1's new DME company.
-The plan was for Resident #1's DME company to deliver her oxygen tanks to her room.
-Staff which included the MA/SIC and the PCAs were expected to notify the RN Supervisor or the

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C 078	Continued From page 4 Administrator of the arrival of Resident #1's oxygen. -Oxygen tanks that were not in use were to be stored securely in the facility's main office. -There had been no staff education for safe oxygen storage. -Oxygen canisters should have been in crates or stands in the facility's main office to store the full and empty oxygen tanks in order to prevent tipping of the oxygen tanks. -She was not aware that the tanks had been stored unsecured on Resident #1's floor. -She did not have a paper copy of the delivery confirmation for Resident #1's oxygen supply. -She had requested Resident #1's delivery confirmation from the DME company and they could not provide her a copy either. -She was not informed of the oxygen canisters stored in Resident #1's room by staff. -She expected staff to notify her of the delivery of Resident #1's oxygen canisters. -It worried her the oxygen canisters were kept unsecured. -Resident #1's door could have slammed into the tanks and there could have been an explosion. Interview with the Administrator on 07/23/21 at 4:25pm revealed: -Resident #1's oxygen tanks should have been delivered to the facility's main office. -If the oxygen tanks were not delivered to the facility's main office and delivered to Resident #1's room the RN supervisor or the Administrator should have been notified of the delivery the same day. -She thought staff had been trained on proper oxygen storage when their Licensed Health Professional Support tasks were completed by the RN Supervisor. -She was in Resident #1's room on 07/20/21 and	C 078		

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C 078	Continued From page 5 did not observe the oxygen canisters. -It was important to properly store oxygen tanks because they did not want the oxygen canisters to fall over and cause an explosion.	C 078		