STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345410	A. BUILDING _____ B. WING _____	C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL CONTINUING CARE	1287 NEWSOME STREET MOUNT AIRY, NC 27030

(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 08/04/24 through 08/07/24. The facility was found in compliance with the requirement of CFR 483.73, Emergency Preparedness. Event ID: LU6W11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation was conducted on 08/04/24 through 08/07/24. Event ID: LU6W11. The following intake was investigated: NC00216201. 5 of the 5 complaint allegations did not result in a deficiency.	F 000		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.	F 655		9/3/24

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

Electronically Signed | 08/30/2024

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F 655	Continued From page 1 §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a baseline care plan that addressed a resident's weight-bearing status and the use of a sling to the right upper extremity for 1 of 1 resident (Resident #47) reviewed for baseline care plan. The findings included: Resident #47 was admitted to the facility on 7/30/2024 with a diagnosis of a right distal clavicle (collarbone) fracture (break). A review of a baseline care plan dated 7/30/2024 revealed Resident #47 had a fracture and staff were to follow rehabilitation orders and/or	F 655	The Nurse Supervisor immediately contacted Northern Orthopedics to notify the provider that Resident #47 had been refusing to wear his right upper extremity sling. The orthopedic provider changed Resident #47 order to utilize sling as needed for comfort. Resident #47 baseline care plan was updated per the provider□s new order. The Director of Nursing and/or her designee re assessed all facility residents that required an assisted device and/or were non-weight bearing to ensure assisted devices were in place and non-weight bearing statuses were documented on resident□s baseline care	

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F 655	Continued From page 2 recommendations. A review of a physician's order dated 7/30/2024 revealed Resident #47 was to always wear sling on his right upper extremity and was non-weightbearing to his right upper extremity. An interview was conducted on 8/6/2024 at 10:05 am with the Care Plan Nurse. The Care Plan Nurse stated a baseline care plan was completed when a resident was admitted to the facility. The Care Plan Nurse stated it was the responsibility of the hall nurse who admitted the resident to complete the baseline care plan. The Care Plan Nurse stated Resident #47 was ordered to always wear a sling to his right upper extremity and was non-weightbearing to his right upper extremity. The Care Plan Nurse verified the sling and weight-bearing status were not on his baseline care plan and should have been. The Care Plan Nurse stated she was not sure why the sling and weight-bearing status were not included because she was not the person who completed the baseline care plan. An interview was conducted on 8/6/2024 at 11:11 am with Nurse #2. Nurse #2 stated she admitted residents to the facility and completed the admission for Resident #47. Nurse #2 stated Resident #47 was wearing a sling to his right upper extremity when he was admitted to the facility. Nurse #2 stated she knew that he was non-weightbearing to his right upper extremity. Nurse #2 verified the baseline care plan did not include the application of a sling to the right upper extremity and the non-weightbearing status of the right upper extremity. Nurse #2 stated the sling and weight-bearing status should have been included in the baseline care plan but she must	F 655	plan. The Staff Development Nurse and/or her designee re-educated all facility nurses on the importance of obtaining baseline care plans within 48 hours of all new resident admissions and adding what is specific to each resident. The Staff Development Nurse and/or her designee will educate all Certified Nursing Assistants of the importance to utilize the daily care guides to ensure all assisted devices are in place, being aware of any resident weight bearing statuses, and the importance of reporting every refusal. The Staff Development Coordinator and/or her designee will educated all nursing staff upon hire of the importance of completing the baseline care plan and utilizing the daily care guides. The care plan nurses will be reviewing all baseline care plans within the 1st week of admission and prior to the comprehensive care plan is initiated. The Director of Nursing and/or her designee will review all new resident admission orders to ensure all assisted devices and/or weight bearing statuses are documented on the baseline care plan and daily care guides. These reviews will be completed on all new resident admissions for 4 weeks and then thereafter auditing new admissions for 3 months to ensure all orders are placed on the baseline care plan correctly. Results of all reviews will be reported to the Quality Assurance and Performance Committee by the Director of Nursing. The Quality Assurance Committee will assess and modify the action place as	

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F 655	Continued From page 3 have forgotten to write that information in. An interview was conducted on 8/7/2024 at 8:24 am with the Director of Nursing (DON). The DON stated the baseline care plan was completed by the hall nurse when a resident was admitted to the facility. The DON stated the baseline care plan should include information/instructions specific to the resident and their needs. The DON stated she was unaware the sling and weight-bearing status had not been documented on the baseline care plan and it should have been. An interview was conducted on 8/7/2024 at 8:31 am with the Administrator. The Administrator was not aware the sling and weight-bearing status for Resident #47 had not been documented on the baseline care plan and stated it should have been.	F 655	needed to ensure continued compliance.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to provide fingernail care for a dependent resident for 1 of 4 residents reviewed for activities of daily living (ADL) (Resident #35). The findings included: Resident #35 was admitted to the facility on	F 677	Resident #35 received ADL care (provided finger nail care) on 8-6-24. The Nurse Supervisor provided fingernail care for Resident #35 and he agreed to have his fingernails cut, cleaned, and filed. The Director of Nursing and/or her designee re assessed all dependent residents to ensure they were all receiving their ADL care, including nail care. Any	9/3/24

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F 677	Continued From page 4 1/26/2024 with diagnosis' which included hemiplegia (inability to move one side of the body). A review of a care plan dated 5/13/2024 revealed Resident #35 had impaired mobility related to left-sided hemiplegia with interventions which included for staff to encourage Resident #35 to participate in activities of daily living (ADL) care as able and to assist him as needed. A review of a quarterly Minimum Data Set (MDS) dated 8/1/2024 revealed Resident #35 was cognitively intact and was not coded for rejection of care. Resident #35 was coded for impairment on one side of his upper extremities and required moderate assistance with personal hygiene. A review of the Electronic Health Record shower documentation dated 8/3/2024 revealed Resident #35 received a shower from Nurse Aide (NA) #1. An observation was conducted on 8/4/2024 at 9:55 am. Resident #35 was observed to have half-inch long fingernails over the tip of the finger with a brown substance noted under all ten fingernails on both hands. An observation was conducted on 8/5/2024 at 8:18 am. Resident #35 was observed to have half-inch long fingernails over the tip of the finger with a brown substance noted under all ten fingernails on both hands. An interview was conducted on 8/5/2024 at 3:11 pm with Resident #35. Resident #35 stated his fingernails had gotten long and he had asked staff to cut his fingernails but was unable to recall when he asked or who he had asked. Resident	F 677	potential areas of concern were addressed accordingly. The Staff Development Coordinator and/or her designee will re-educate all nursing staff on the importance of ensuring all dependent residents receive (ADL) Activities of Daily Living. The Staff Development Cooridnator and/or her designee will educate all new nursing staff of the importance to ensure all resident recieve their ADLs. This will occur during all new staff orientation. All nursing staff will also be re-educated to ensure all independent residents receive the appropriate care. All shower teams will be re-educated on the importance of performing fingernail care during each resident shower. Shower sheets were provided for the shower team to remind staff to assess fingernails and give them a place to document. The nail care list that informs the CNAs of which resident□s nails they are allowed to trim and which resident□s nails need to be trimmed by a nurse was updated and placed in the binder with the shower sheets as well as placed in the daily care guide binder down each hall. The Director of Nursing and/or her designee will assess all facility residents to ensure which residents need the appropriate (ADL) Activities of Daily Living Care. The Director of Nursing and/or her designee will review shower team documentation to ensure nail care is performed each time a resident is showered. These reviews will be done weekly on all showers for 4 weeks and then thereafter auditing showers for 3	

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F 677	Continued From page 5 #35 stated his fingernails "look awful" and had been snagging his bedding. An interview was conducted on 8/5/2024 at 3:15 pm with NA #2. NA #2 stated she was assigned Resident #35 and worked second shift (3:00 pm to 11:00 pm). NA #2 stated she was not sure who was responsible for cleaning and cutting fingernails and stated any NA could clean underneath fingernails. NA #2 observed Resident #35's fingernails and agreed that they were long, dirty, and need to be cleaned and cut. NA #2 stated she had not noticed his fingernails and had not offered to cut or clean his fingernails. An interview was conducted on 8/6/2024 at 9:54 am with NA #4. NA #4 stated she worked first shift (7:00 am to 3:00 pm) and was on the shower team. NA #4 stated the shower team was primarily responsible for cleaning and cutting nails. NA #4 stated Resident #35 was scheduled to receive showers on Tuesdays, Thursdays, and Saturdays. NA #4 stated she had given Resident #35 a shower last week and he had refused to have his nails cut, but she reported she cleaned his nails when she gave him a shower. An interview was conducted on 8/6/2024 at 9:01 am with the Charge Nurse. The Charge Nurse stated the shower team was responsible for providing nail care. The Charge Nurse stated that Resident #35 would occasionally refuse to have his fingernails cut. The Charge Nurse was not aware that Resident #35's fingernails were long and dirty. An interview was conducted on 8/6/2024 at 1:48 pm with NA #1. NA #1 stated she worked on second shift (3:00 pm to 11:00 pm) and was	F 677	months to ensure all residents receive the appropriate fingernail care. Results of all reviews will be reported to the Quality Assurance and Performance Committee by the Director of Nursing. The Quality Assurance Committee will assess and modify the action place as needed to ensure continued compliance.	

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F 677	Continued From page 6 assigned Resident #35. NA #1 stated she had not given Resident #35 a shower or performed nail care that day and stated she had documented she had given Resident #35 a shower to get the task to go away. NA #1 stated the shower team was responsible for completing nail care and stated she had not noticed Resident #35's fingernails and reported he had not asked her to cut and clean his fingernails. A follow-up interview was conducted on 8/6/2024 at 10:01 am with the Charge Nurse. The Charge Nurse stated she went and performed fingernail care for Resident #35 and that he had agreed to have his fingernails cut, cleaned, and filed. An interview was conducted on 8/7/2024 at 8:17 am with the Director of Nursing (DON). The DON stated nail care was performed by the shower team on the resident's shower days. The DON stated NAs and Nurses on the hall could perform nail care, but nail care was primarily completed by the shower team. The DON stated she was not aware Resident #35 had long, dirty nails. An interview was conducted on 8/7/2024 at 8:28 am with the Administrator. The Administrator stated he was not aware Resident #35 had long, dirty fingernails but knew that he did not like to have his fingernails cut.	F 677		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical	F 690		9/3/24

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F 690	Continued From page 7 condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews the facility failed to secure an indwelling urinary catheter tubing to prevent tension or trauma for 1 of 3 residents reviewed for urinary catheter (Resident #86). The finding included:	F 690	Resident #86 immediately had their catheter strap secured in place on 8-4-24 by nursing staff. The Director of Nursing and/or her designee re assessed all facility residents who have a physician order for an indwelling catheter to ensure all catheter straps were secured in proper placement.	

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F 690	Continued From page 8 Resident #86 was admitted to on 08/02/24 to the facility with diagnoses that included urinary retention. The baseline care plan dated 08/02/24 revealed Resident #86 was alert and oriented to person and to check catheter strap every shift. The admission Minimum Data Set assessment was not yet completed as of 08/07/24. A review of Resident #86's physician orders dated 08/02/24 revealed an order for a urinary catheter to straight drainage due to the diagnosis of urinary retention. There was also an order to check placement of a catheter strap every shift. On 08/04/24 at 9:49 AM an observation was made of Resident #86 lying in bed with an indwelling urinary catheter attached to the left side of the bed frame. When asked the Resident uncovered her left thigh to show there was no stabilizing device present on the catheter tubing to prevent tension or trauma. A review of Resident #86's Treatment Administration Record (TAR) for 08/2024 revealed the catheter strap placement check was initialed off as completed at 2:30 PM on 08/04/24 by Nurse #1. On 08/05/24 at 2:54 PM an observation was made of Resident #86 being toileted by Nurse #4 and Nurse Aide (NA) #5. It was noted that the Resident did not have a stabilizing device in place on the catheter tubing to prevent tension or trauma. An interview was conducted with Nurse #4 and	F 690	The Staff Development Coordinator and/or her designee re-educated all nursing staff of the importance of ensuring all residents with indwelling catheters have catheter straps properly secured in place. The Staff Development Coordinator and/or her designee will educate all nursing staff upon hire of ensuring all residents with indwelling catheters have catheter straps properly secured in place. This will occur during the orientation process. Education will be completed on the importance of properly secured catheter straps, to keep urinary catheters straight for proper drainage. The Director of Nursing and/or her designee will review all residents with a physician order for an indwelling catheter. These reviews will include, ensuring that all residents with indwelling catheters have a catheter strap secured in place for proper drainage. These reviews will be done weekly on all residents with indwelling catheters for 4 weeks and monthly thereafter to ensure catheter straps are secured in place. Results of all reviews will be reported to the Quality Assurance and Performance Committee by the Director of Nursing. The Quality Assurance Committee will assess and modify the action place as needed to ensure continued compliance.	

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F 690	Continued From page 9 NA #5 on 08/05/24 at 2:54 PM. The staff explained that they both got Resident #86 up out of bed and dressed earlier that morning and did not notice that the Resident did not have a stabilizing device in place for the catheter tubing. Nurse #4 stated it was protocol that they used stabilizing devices on all residents with urinary catheters. During an interview with Nurse #1 on 08/06/24 at 1:58 PM the Nurse confirmed that she initialed the TAR on 08/04/24 to indicate that Resident #86 had a stabilizing device in place. The Nurse explained that when she checked the Resident she was up in her wheelchair and could not positively determine the device was in place but thought it was, so she initialed the TAR to indicate she checked it. Nurse #1 stated she should not have initialed the TAR unless she was sure the device was in place. During an interview with the Director of Nursing (DON) on 08/07/24 at 8:59 AM the DON explained that it was policy that residents who have an indwelling urinary catheter have a stabilizing device in place to prevent tension and trauma.	F 690		
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,	F 695		9/3/24

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F 695	Continued From page 10 and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to post cautionary safety signs that indicated the use of oxygen for 5 of 7 residents reviewed for oxygen use (Resident #47, #30, #48, #19, and #70). The findings included: a. Resident #47 was admitted to the facility on 7/30/2024 with a diagnosis of respiratory failure. A physician's order dated 7/30/2024 revealed Resident #47 was ordered to wear 2 liters per minute of oxygen continuously. An observation was conducted on 8/4/2024 at 9:56 am. Resident #47 was observed with his eyes closed in bed and oxygen being administered at a rate of 2 liters per minute via nasal cannula. There was no oxygen signage outside of Resident #47's room or on the doorframe. An interview was conducted on 8/5/2024 at 3:34 pm with Medication Aide (MA) #1. MA #1 stated when a resident was ordered oxygen, there was an order on the Medication Administration Record (MAR). MA #1 stated the nurses let the Nurse Assistants (NAs) know if a resident was ordered oxygen. MA #1 stated the facility staff used to have an indication outside of the room that oxygen was in use but stopped due to the signage being a violation of the resident's privacy. An observation was conducted on 8/5/2024 at 5:00 pm. Resident #47 was observed with his	F 695	All facility residents who have physician orders to receive oxygen will have the appropriate signage placed on their door or door frame stating, oxygen in use. The Director of Nursing and/or her designee re assessed physician orders to ensure that all residents with an order for oxygen have the proper signage posted on their door or door frame stating, oxygen in us. The Staff Development Coordinator will re-educate all facility nurses on the importance of when any resident receives an order for oxygen that the proper signage is put in place on the resident□s door or door frame stating, oxygen in use. The Staff Development Cooridnator and/or her designee will educate all nursing staff upon hire of the importance of when any resident receives an order for oxygen that the proper signage is put in place on the resident□s door or door frame stating, oxygen in use. This will occur during the orientation process. The Director of Nursing and/or her designee will review all residents with a physician order for an oxygen use. These reviews will include, ensuring that all residents with the use of oxygen have the proper signage put in place on their door or door frame stating, oxygen in use. These reviews will be done weekly on all residents with orders for oxygen 4 weeks and monthly thereafter to ensure signage is placed as appropriate. Results of all reviews will be reported to the Quality	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL CONTINUING CARE	1287 NEWSOME STREET MOUNT AIRY, NC 27030

(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
F 695	Continued From page 11 eyes closed in bed and oxygen being administered at a rate of 2 liters per minute via nasal cannula. There was no oxygen signage outside of Resident #47's room or on the doorframe. An observation was conducted on 8/6/2024 at 8:09 am. Resident #47 was observed awake in bed and oxygen was being administered at a rate of 2 liters per minute via nasal cannula. There was no oxygen signage outside of Resident #47's room or on the doorframe. An interview was conducted on 8/6/2024 at 9:04 am with the Charge Nurse. The Charge Nurse stated if a resident was supposed to wear oxygen there was an order in the chart from the physician. The Charge Nurse stated she was unsure if the facility still used oxygen signage outside of resident rooms to indicate that oxygen was in use. An interview was conducted on 8/7/2024 at 8:22 am with the Director of Nursing (DON). The DON stated if a resident was on oxygen, oxygen usage was displayed on the resident's vital signs in the Electronic Health Record (EHR). The DON stated the facility did not use oxygen signage outside of resident rooms because they had been told that was a violation of the resident's privacy. An interview was conducted on 8/7/2024 at 8:33 am with the Administrator. The Administrator stated that in the past, the facility would place a magnet outside of the resident's room if oxygen was in use but had stopped because they were told that was a privacy/dignity issue. b. Resident #70 was readmitted to the facility on	F 695	Assurance and Performance Committee by the Director of Nursing. The Quality Assurance Committee will assess and modify the action place as needed to ensure continued compliance.	

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09/06/23 with diagnoses that included chronic obstructive pulmonary disease and shortness of breath.

Review of physician order dated 09/06/23 read: oxygen at 3 liters via nasal cannula continuously.

Review of the quarterly Minimum Data Set (MDS) dated 06/12/24 revealed that Resident #70 was cognitively intact and required the use of oxygen.

An observation of Resident #70 was made on 08/04/24 at 1:04 PM. Resident #70 was resting in bed and was noted to have oxygen in use at 3 liters per minute via nasal cannula. There was no cautionary signs noted on the door frame or in Resident #70's environment where the oxygen was being delivered.

An observation of Resident #70 was made on 08/05/24 at 10:33 AM. Resident #70 was resting in bed and was noted to have oxygen in use at 3 liters per minute via nasal cannula. There was no cautionary signs noted on the door frame or in Resident #70's environment where the oxygen was being delivered.

An interview was conducted on 8/6/2024 at 9:04 am with the Charge Nurse. The Charge Nurse stated if a resident was supposed to wear oxygen there was an order in the chart from the physician. The Charge Nurse stated she was unsure if the facility still used oxygen signage outside of resident rooms to indicate that oxygen was in use.

An observation of Resident #70 was made on 08/06/24 at 11:24 AM. Resident #70 was resting in bed and was noted to have oxygen in use at 3

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liters per minute via nasal cannula. There was no cautionary signs noted on the door frame or in Resident #70's environment where the oxygen was being delivered.

Nurse Aide (NA) #6 was interviewed on 08/06/24 at 2:22 PM. She stated that Resident #70 wore his oxygen all the time when in his room and if he was out of his room, they obtained him a portable oxygen tank to use. NA #6 stated she was not sure if the facility used oxygen signs or no smoking signs, but she did not think there was any signs on Resident #70 door or in his room that indicated no smoking or that oxygen was in use.

Nurse #5 was interviewed on 08/06/24 at 4:24 PM. Nurse #5 stated that she was not sure about any cautionary signs within the facility, but she thought the front door of the facility stated, "no smoking." She stated she would have to find out if the facility used cautionary signs on the doors or in resident rooms where oxygen was being used.

An interview was conducted on 8/7/2024 at 8:22 am with the Director of Nursing (DON). The DON stated if a resident was on oxygen, oxygen usage was displayed on the resident's vital signs in the Electronic Health Record (EHR). The DON stated the facility did not use oxygen signage outside of resident rooms because they had been told that was a violation of the resident's privacy.

An interview was conducted on 8/7/2024 at 8:33 am with the Administrator. The Administrator stated that in the past, the facility would place a magnet outside of the resident's room if oxygen was in use but had stopped because they were

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told that was a privacy/dignity issue.

c. Resident #19 was admitted to the facility on 06/12/20 and had diagnoses that included respiratory failure and hypercapnia (abnormal carbon dioxide levels in the blood).

Review of Resident #19's Minimum Data Set dated 06/07/24 revealed his cognition was severely impaired and he wore oxygen.

A review of Resident #19's physician orders dated 03/22/24 revealed an order for continuous oxygen at 2 liters per minute via nasal cannula.

An observation made on 08/04/24 at 10:19 AM revealed Resident #19 was wearing oxygen via nasal cannula, and it was being delivered by an oxygen concentrator. There was no oxygen cautionary sign posted near the Resident's room to indicate that oxygen was in use.

Subsequent observations made on 08/05/24 at 11:06 AM and 2:49 PM and on 08/06/24 at 8:30 AM and 9:07 AM revealed Resident #19 wore continuous oxygen via nasal cannula and there were no oxygen cautionary signs posted near the Resident's room.

On 08/06/24 at 10:40AM during an interview with the Charge Nurse, she stated that they did not post oxygen signs on the residents' doors anymore because it was a dignity issue.

During an interview with the Director of Nursing (DON) on 08/07/24 at 8:22 AM she explained the facility did not utilize the cautionary oxygen signs throughout the facility because the facility was smoke free which included vapes (electronic

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cigarettes) and were not allowed in the facility. The DON indicated the oxygen cautionary signs were a violation of the residents' privacy.

An interview was conducted on 8/7/2024 at 8:33 AM with the Administrator. The Administrator stated the facility was smoke free. The Administrator stated that in the past, the facility would place a magnet outside of the resident's room if oxygen was in use but had stopped because they were told that was a privacy/dignity issue.

d. Resident #30 was admitted to the facility on 05/01/23 with diagnoses that included chronic obstructive pulmonary disease (COPD), and chronic respiratory failure.

Review of Resident #30's most recent quarterly Minimum Data Set assessment dated 07/18/24 revealed she was cognitively intact. She was coded with having shortness of breath or trouble breathing while lying flat and was coded as utilizing oxygen therapy while admitted to the facility.

A review of Resident #30's care plan revealed a care plan area for "[Resident #30] has the diagnoses of COPD a d respiratory failure and requires oxygen therapy". Interventions included to administer her oxygen as ordered and ensure that Resident #30's oxygen supply was available as needed.

Review of Resident #30's physician orders revealed the following orders:
- Check oxygen saturation every shift and record results - may increase oxygen as needed to maintain oxygen saturation at greater than 92%.

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- Continuous oxygen at 2 liters per minute via a nasal cannula.

An observation of Resident #30 completed on 08/04/24 at 10:22 AM revealed resident to be in her wheelchair in her room. Resident was observed with her nasal cannula on her face and was receiving oxygen from her room concentrator at 2 liters per minute. An observation of Resident #30's room and doorway revealed no documented signage indicating the use of oxygen in the room.

An additional observation of Resident #30's room and doorway completed on 08/05/24 at 2:55 PM continued to revealed no documented signage that indicated oxygen was in use in the room.

An interview with Nurse Aide #6 on 08/05/24 at 3:15 PM revealed she was aware the Resident #30 wore oxygen. She further reported she was unsure if the facility utilized oxygen in use signs and verified that there was not one in Resident #30's room or on her doorway.

An interview was conducted on 8/7/2024 at 8:22 am with the Director of Nursing (DON). The DON stated if a resident was on oxygen, oxygen usage was displayed on the resident's vital signs in the Electronic Health Record (EHR). The DON stated the facility did not use oxygen signage outside of resident rooms because they had been told that was a violation of the resident's privacy.

An interview was conducted on 8/7/2024 at 8:33 am with the Administrator. The Administrator stated that in the past, the facility would place a magnet outside of the resident's room if oxygen was in use but had stopped because they were

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told that was a privacy/dignity issue.

e. Resident #48 was admitted to the facility on 07/19/22 with diagnoses that included chronic respiratory failure with hypoxia.

Review of Resident #48's most recent quarterly Minimum Data Set assessment dated 07/18/24 revealed resident to be moderately impaired. Resident #48 was coded as having shortness of breath with exertion and shortness of breath when lying flat. Resident #48 was coded as receiving oxygen therapy while admitted to the facility.

Review of Resident #48's care plan last updated 07/19/24 revealed a care plan for: "[Resident #48] has chronic respiratory failure and requires oxygen therapy". Interventions included to administer oxygen as ordered, ensure the [Resident #48's] oxygen supply is available at all times, and oxygen at 2 liters per minute via nasal cannula continuously - check oxygen saturations every shift and record results.

Review of Resident #48's physician orders revealed the following order:
- Oxygen at 2 liters per minute via nasal cannula continuously - check oxygen saturation every shift and record results, may titrate as needed to maintain oxygen saturation greater than 92%.

An observation of Resident #48 completed on 08/04/24 at 12:34 PM revealed resident to be in her room. Resident #48 was observed with her nasal cannula on her face and was receiving oxygen from her room concentrator at 2 liters per minute. An observation of Resident #48's room and doorway revealed no documented signage

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indicating the use of oxygen in the room.

An additional observation of Resident #48's room and doorway completed on 08/05/24 at 2:59 PM continued to revealed no documented signage that indicated oxygen was in use in the room.

An interview with Nurse Aide #6 on 08/05/24 at 3:21 PM revealed she was aware the Resident #48 wore oxygen. She further reported she was unsure if the facility utilized oxygen in use signs and verified that there was not one in Resident #48's room or on her doorway.

An interview was conducted on 8/7/2024 at 8:22 am with the Director of Nursing (DON). The DON stated if a resident was on oxygen, oxygen usage was displayed on the resident's vital signs in the Electronic Health Record (EHR). The DON stated the facility did not use oxygen signage outside of resident rooms because they had been told that was a violation of the resident's privacy.

An interview was conducted on 8/7/2024 at 8:33 am with the Administrator. The Administrator stated that in the past, the facility would place a magnet outside of the resident's room if oxygen was in use but had stopped because they were told that was a privacy/dignity issue.