STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345496	A. BUILDING _____ B. WING _____	C 09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NURSING & REHAB ALAMANCE	791 BOONE STATION DRIVE BURLINGTON, NC 27215

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 09/23/24 through 09/27/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # FHH011.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 09/23/24 through 09/27/24. Event ID# FHH011. The following intake was investigated NC00220791. 1 of the 1complaint allegation did not result in any deficiency.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the	F 578		10/10/24

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

Electronically Signed | 10/10/2024

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F 578	Continued From page 1 facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to have accurate advanced directive documentation throughout the medical record for 1 of 6 residents reviewed for advanced directives (Resident #51). The findings included: Resident #51 was initially admitted to the facility on 12/6/2021 and had a reentry date of 9/26/2023. Her diagnoses included cerebral infarction (a disruption to blood supply that is severe enough and long enough in duration to result in tissue death), Type II diabetes, and chronic kidney disease. The electronic medical record profile indicated Resident #51's code status as a cardiopulmonary	F 578	F578 1. Corrective action for resident(s) affected by the alleged deficient practice: A chart review was initiated by the Director of Nursing (DON) on 9/24/2024 in direct relation to Resident #51 identified during the survey process. The review showed that advanced directive documentation throughout the resident's medical record was not up to date. Code status, care plan and orders for Resident #51 were immediately updated per resident/RP preference by the DON and a new Advanced Directive form was completed ON 9/26/2024. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice:	

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F 578	Continued From page 2 resuscitation (CPR)/Full Code. Review of Resident #51's physician orders dated 9/26/2023 revealed her Do Not Resuscitate (DNR) order was discontinued; she was CPR/Full Code status. Review of Resident #51's electronic medical record revealed a signed Advance Directive form dated 9/26/2023 which indicated no code (DNR) status. Review of the quarterly Minimum Data Set (MDS) assessment dated 7/11/2024 revealed Resident #51 was moderately cognitively impaired. Review of Resident #51's care plan last reviewed on 8/5/2024, showed a focus area of do not attempt resuscitation. An interview was conducted on 9/24/2024 at 1:51 PM with Nurse #6. She stated when she verified code status, she first checked the banner in the electronic medical record (EMR). She stated she also looked in the medication administration record (MAR), and if she found a discrepancy, she notified the Director of Nursing (DON) and called the physician. An interview was conducted on 9/24/2024 at 3:03 PM with Nurse #7. She stated she spoke to Resident #51 at the time of readmission on 9/26/2023 regarding her code status. She stated Resident #51 told her she wanted to have CPR. Nurse #7 added Resident #51 was readmitted to the facility with a full code order and Nurse #7 was not aware that she needed to fill out a new form that reflected a change to Full Code status.	F 578	All residents have the potential to be affected by the alleged deficient practice. On 9/24/2024, the DON initiated an initial audit of 100% of current residents code status. The purpose of this initial audit is to ensure code status preference, orders, and care plan match for all current residents. The same audit will be completed by the DON and/or designee for all new admissions. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Immediate education on Advanced Directives policy was initiated on 10/4/24 with all Licensed Nurses, (RN's/LPN's) including agency by DON. A Code status audit will be conducted for all new admissions by DON and/or designee and will be brought to the clinical meeting for review by IDT. As of 10/9/2024, any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The DON and/or designee will continue to monitor Advance Directives for any new admissions and any current residents for a sample of at least 5 residents for changes in code status to ensure compliance. Monitoring will be completed weekly x 3 weeks and monthly x 2 months. Reports will be presented to the monthly QA committee by the DON or designee to ensure corrective action is	

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F 578	Continued From page 3 An interview was conducted on 9/24/2024 at 2:08 PM with the DON. She stated a resident's code status was verified when staff checked the banner in a resident's EMR, reviewed the advanced directive document in the EMR, and verified the code status with the physician order. An interview was conducted on 9/25/2024 at 3:26 PM with the Social Worker (SW). She could not explain the discrepancy in Resident #51's code status. She was unable to locate documentation regarding Resident #51's change in code status within the EMR. An interview was conducted on 9/26/2024 at 3:52 PM with the Medical Director. He stated he relied on the documentation to be correct in a resident's chart. The Medical Director added he expected that staff ensured code status documentation was accurate when a resident returned to the facility.	F 578	initiated as appropriate. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Compliance Date: 10/10/24 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.	
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the discharge status on the discharge Minimum Data Set (MDS) assessment and oxygen therapy on the admission MDS assessment for 2 of 23 residents reviewed for MDS assessment accuracy. (Resident #97 and Resident #24). Findings included:	F 641	F641 1. Corrective action for resident(s) affected by the alleged deficient practice. Documentation related to discharge MDS for Resident #97 and oxygen use MDS for Resident #24 was reviewed by the Director of Nursing (DON) and the Minimum Data Set (MDS) Coordinator on 9/25/2024. The review was in direct relation to observations made during the	10/10/24

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F 641	Continued From page 4 1. Resident #97 was admitted to the facility on 6/26/26. Review of the physician discharge order dated 7/5/24 revealed Resident #97 was to discharge home on 7/5/24 with home health services related to home bound status. Home health physical therapy and occupation therapy to evaluate and treat. Home health Aide for Activities of Daily living support. Record review of the nurses' notes, dated 7/5/24 revealed Resident #97 was discharged home per his request on 7/5/24. Resident #97 was discharged with home care agency set up, ordered durable medical equipment, and follow up appointment scheduled. The Nurse Practitioner was present at discharge. Record review of the Discharge Minimum Data Set (MDS) assessment, dated 7/5/24, revealed Resident #97 was coded as having been discharged to an acute hospital. On 9/25/24 at 9:35 AM, during an interview, Nurse # 1 indicated Resident #97 was discharged home with his family and home care set up. On 9/25/24 at 9:40 AM, during an interview, MDS Coordinator, indicated the resident had a planned discharge home on 7/5/24. The nurse stated the discharge MDS dated 7/5/24 for Resident #97 was incorrectly coded as discharge to an acute hospital. 2. Resident #24 was admitted on 7/8/24 with diagnoses that included chronic obstructive pulmonary disease (COPD), dependence on supplemental oxygen, and chronic respiratory failure with hypoxia.	F 641	survey process. The result of the review indicated modification adjustments needed to the discharge MDS for Resident #97. The corrective action was completed for Resident #97 by the MDS Coordinator on 9/25/2024. The result of the review also indicated modification adjustments needed to the oxygen use MDS for Resident #24. The corrective action was completed for Resident #24 by the MDS Coordinator on 9/25/2024. 2. Corrective action for residents with the potential to be affected by the alleged deficient All discharged residents have the potential to be affected by the alleged deficient practice. On 10/4/2024 the MDS Coordinator completed a Discharge audit of residents discharged in the last 14-30 days (sample of at least 10) to ensure compliance with discharge location on last MDS completed. Look-back time frame of 9/18/2024 to 10/4/2024. An Oxygen audit tool will be utilized to review all residents with current orders for oxygen to ensure compliance with coding oxygen use for the Look-back time frame of 9/18/2024 to 10/4/2024 by the DON, MDS Coordinator and/or designee. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice. On 10/07/2024, the Clinical Reimbursement Consultant completed an in-service training for the facility Minimum Data Set (MDS) nurse(s) and those that	

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F 641	Continued From page 5 Review of Resident #24's physician order dated 7/8/24 indicated Oxygen at 3 Liters (L) continuous via nasal cannula. Check every shift for Oxygen supplement. Oxygen saturation levels to be checked every shift. Nursing note dated 7/10/24 revealed Resident #24 was on continuous Oxygen at 3 L via nasal cannula. The resident was not in any acute distress. Review of the admission Minimum Data Set (MDS) Assessment dated 7/15/24 indicated the resident was assessed as moderately cognitively impaired and was not coded for oxygen use. During an interview on 9/24/24 at 2:41 PM, Nurse #7 stated Resident #24 had a long history of COPD and was admitted on continuous oxygen. The resident was on 3 L, continuous oxygen via nasal cannula. The resident has no distress, and able to tolerate her supplemental oxygen. During an interview on 9/25/24 at 10:38 AM, the MDS Coordinator stated Resident #24 was admitted with oxygen therapy. The MDS Coordinator indicated it was an oversight and MDS was inaccurately marked as not receiving oxygen. On 9/25/24 at 10:10 AM, during an interview, the Director of Nursing (DON) expected the staff to complete MDS data correctly and on time. She continued that it was an error by the MDS nurse and the MDS nurse was in the process of correcting it.	F 641	contribute to the MDS (Social services director, Dietary, Therapy Director and Nursing, that included the importance of thoroughly reviewing the medical record for the discharge status and oxygen use requirements. This information will be integrated into the standard orientation training by the DON and/or designee and will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 10/9/2024, any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. 4. Monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Director of Nursing or designee will review Minimum Data Set Assessments (discharge tracking records) and order listing report for oxygen orders for 5 residents to ensure accuracy of coding of MDS items utilizing the Accurate Coding of MDS Audit Tool. This audit will be done weekly x 3 weeks and then monthly x 2 months. Reports will be presented to the monthly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary	

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F 641	Continued From page 6	F 641	Manager and the Activity Director. Date of Compliance: 10/10/2024 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.	
F 655 SS=B	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		10/10/24

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F 655	Continued From page 7 §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, resident interview, family interview, and staff interviews, the facility failed to provide the resident and their representative with a summary of the baseline care plan for 2 of 2 residents reviewed for care plans. (Resident #51 and Resident #248) Findings included: 1. Resident #51 was admitted to the facility on 9/4/24. Baseline care plan meeting documentation dated 9/6/24 indicated Resident #51 would prefer discharge to assistant living or if resident did not improve then the resident would continue in the	F 655	F655 1. Corrective action for resident(s) affected by the alleged deficient practice: Baseline Care Plans were reviewed for Resident #51 and Resident #248 by the Administrator and Social Services Director on 9/25/2024. This review was completed in direct relation to observations made during the survey process. The result of the review determined that documentation needed to be obtained for both Resident #51 and Resident #248 to show that a copy of the baseline care plan was given to resident/RP. Baseline care plans for both residents were reviewed with the resident, copies provided and uploaded	

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F 655	Continued From page 8 long-term care unit. The durable medical equipment that was needed at discharge and Resident #51's code status was discussed in the meeting. The document indicated the Social Worker (SW) and MDS coordinator attended the meeting. There was no indication that a copy of the baseline care plan was given to the resident's family member. The admission Minimum Data Set (MDS) assessment dated 9/11/24 revealed Resident #51 was assessed as severely cognitively impaired. During an interview on 9/23/24 at 11:48 AM Resident #51 indicated she was recently admitted to the facility. The resident stated she does not recollect having received care plan documentation provided to her or her family member after resident's admission to the facility During an interview on 9/25/24 at 12:05 PM, the Social Worker (SW) stated the baseline/ Admission care plan meeting was usually conducted with the resident and/or resident representative within 72 hours of resident's admission. The SW further stated that the MDS coordinator and therapy staff were present during the care plan meeting. Resident #51's representative and MDS coordinator were present for the baseline care plan meeting. The baseline care plan meeting was held on 9/6/24. The SW stated she had not been providing the residents and their representatives with a summary of the baseline care plan. 2. Resident # 248 was admitted to the facility on 9/19/24. Baseline care plan meeting documentation dated	F 655	into the medical record once signed. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 10/7/2024, the Director of Nursing (DON) and Minimum Data Set (MDS) coordinator initiated an audit of 100% of the current resident admissions/readmissions in the last 30 days to the facility to ensure that there was evidence the resident or resident representative received a summary of their baseline care plan. The audit was completed on 10/7/2024. The result of the audit showed that at least one resident out of the list did not have a signed baseline care plan completed within 48hrs and uploaded into the medical record. Corrective action initiated. All other residents or resident representatives were provided with a summary of the baseline care plan. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Immediate education was initiated by the DON on 10/7/2024 to include Nurse Administration, Social Services Director and MDS on the following topics: Baseline Care Plan completion time and initiation. Review of the Base Line Care Plan Requirements including providing copy for resident/resident representative with supporting signed documentation. This information has been integrated into the standard orientation training and will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 10/9/2024, any staff	

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F 655	Continued From page 9 9/20/24 indicated the meeting was attended by resident's representative and family member, SW, therapy staff and MDS coordinator. Document indicated Resident #248's discharge planning and code status were discussed in the meeting. There was no indication that a copy of the baseline care plan was given to the resident's family member. During an interview on 9/23/24 at 2:23 PM, Resident #248's representative indicated that the resident was admitted to the facility few days ago. The resident's representative stated she does not recollect having received care plan documentation provided to her after resident's admission to the facility. During an interview on 9/25/24 at 12:05 PM, the SW stated the resident's baseline care plan meeting was attended by the resident's representative, resident's family member, therapy staff and MDS coordinator. The baseline care plan meeting was held on 9/20/24. The SW stated she had not been providing the residents and their representatives with a summary of the baseline care plan. During an interview on 9/26/24 at 12:04 PM, the Administrator indicated all new admission resident's baseline care plan should be completed with resident and /or resident's representative within 48 hours of admission. A copy of baseline care plan should be provided to the resident and /or attending representative. The Administrator stated the SW was unaware that a copy of the baseline care plane should be provided to the resident and /or resident representative.	F 655	who does not receive the scheduled in-service training will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor compliance utilizing the F655 Quality Assurance Tool weekly x 3 weeks then monthly x 2 months. The DON or designee will monitor 5 newly admitted residents or readmissions for compliance with initiating base line care plans within the specified time frame and provide the resident and/or their representative with a summary of the baseline care plan. Reports will be presented to the monthly Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The monthly QA Meeting is attended by the Administrator, Director of Nurses, Assistant Director of Nurses, Minimum Data Set Nurses, Therapy Manager, RN Unit Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager.	

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F 695	Continued From page 10	F 695		
F 695 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 observations, record reviews and staff interviews, the facility failed to post cautionary signage outside the resident's room to indicate supplemental oxygen (O2) was in use for 2 of 3 residents reviewed for respiratory care (Resident #63 and Resident #24). The findings included: 1. Resident #63 was admitted to the facility on 3/5/24 with diagnoses which included chronic respiratory failure, interstitial pulmonary disease (a group of lung disorders that cause inflammation or scarring of the lungs and air sacs), and chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs). Review of Resident #63's physician's orders revealed she had an oxygen order dated 4/19/2024 for oxygen supplementation at 4 L (liters) continuous via nasal cannula (a device that delivers extra oxygen through a tube and into the nose).	F 695	F695 1. Corrective action for resident(s) affected by the alleged deficient practice: On 9/25/2024 a corrective action was obtained for Resident #63 and #24. Oxygen signs were placed outside the resident□s door. Placement of signs was completed by the DON in direct relation to observations made during the survey process. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents requiring oxygen have the potential to be affected by the alleged deficient practice. On 9/26/2024, the DON began identification of residents that were potentially impacted by this practice. This audit consisted of 100% of the current residents with current oxygen use. The purpose of this audit was to ensure there was an oxygen sign outside the door of all residents on oxygen. This audit was completed on 9/26/2024. Results included	10/10/24

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	345496	A. BUILDING _____ B. WING _____	C 09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NURSING & REHAB ALAMANCE	791 BOONE STATION DRIVE BURLINGTON, NC 27215

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F 695	Continued From page 11 Resident #63's quarterly Minimum Data Set dated 7/27/24 revealed she was severely cognitively impaired and was coded for oxygen use. Observations on 9/24/24 at 1:45 PM and 9/25/24 at 10:17 AM revealed Resident #63 was in her room wearing a nasal cannula for supplemental oxygen. There was no signage outside Resident #63's room indicating supplemental oxygen was in use. An interview was conducted on 9/25/24 at 10:20 AM with Nurse #5. She stated Resident #63 was on 4 l NC continuous oxygen (O2) therapy since April 2024. She stated nursing was responsible for putting the O2 sign on a resident's door. She added Resident #63 had moved rooms and staff may not have taken the O2 sign from her door when they moved her into her new room. An interview was conducted on 9/25/24 at 10:52 AM with the Director of Nursing (DON). She stated nursing was responsible for putting O2 signs on a resident's door. 2. Resident #24 was admitted on 7/8/24 with diagnoses that included chronic obstructive pulmonary disease (COPD), dependence on supplemental oxygen, and chronic respiratory failure with hypoxia. Review of Resident #24's physician order dated 7/8/24 indicated Oxygen at 3 Liters (L) continuous via nasal cannula. Check every shift for Oxygen supplement. Oxygen saturation levels to be checked every shift. Review of the admission Minimum Data Set (MDS) Assessment dated 7/15/24 indicated the resident was assessed as moderately cognitively impaired and was not coded for oxygen use.	F 695	all sampled residents had an oxygen sign placed outside of their door as indicated and updated care plans. No further corrective action was needed at that time. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 9/25/2024, the DON began immediate re-education of all facility Licensed Nurses, Registered Nurses (RN□s) and Licensed Practical Nurses (LPN□s), including agency, on appropriate placement of oxygen signs on resident□s door as indicated. This information will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 10/9/2024, any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The DON and/or designee will complete review of random residents with current oxygen use to ensure compliance with oxygen signage. This monitoring audit will consist of monitoring 5 random residents on oxygen to ensure compliance and that the respiratory care was reflective of residents orders, and care plans. Monitoring will be completed weekly x 3 weeks and monthly x 2 months by the DON and/or designee. Reports will be presented to the monthly QA committee by the DON or designee to ensure corrective action is initiated as	

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F 695	Continued From page 12 Resident #24 comprehensive care planned dated 7/15/24 included focus area related to COPD and the need for continuous oxygen therapy for COPD. Intervention included providing oxygen therapy as ordered by the physician. An observations was conducted on 9/24/24 at 10:04 AM as Resident #24 was lying in her bed with supplemental oxygen provided via nasal cannula by an oxygen concentrator placed next to her bed. There was no signage placed on the resident's door or anywhere near the entry to Resident #24's room to indicate oxygen was in use. An observation was conducted on 9/25/24 at 9:32 AM as Resident #24 was lying in her bed with supplemental oxygen provided via nasal cannula by an oxygen concentrator placed next to her bed. There was no signage placed on the resident's door or anywhere near the entry to Resident #24's room to indicate oxygen was in use. During an interview on 9/24/24 at 2:41 PM, Nurse #7 stated Resident #24 had a long history of COPD and was admitted on continuous oxygen. The resident was on 3 L, continuous oxygen via nasal cannula. The resident has no distress, and able to tolerate her supplemental oxygen. During an observation and interview on 9/25/24 at 9:42 AM, the 3 red signages "Oxygen in Use" were placed on the door of the nursing station. Nurse #8 indicated Resident #24 was 3 L of supplemental oxygen. Nurse #8 stated the oxygen signage should be placed on the resident's room doorway. She was unsure why it	F 695	appropriate. The monthly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process. Date of Compliance: 10/10/2024	

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F 695	Continued From page 13 was not place near the entrance of the nursing station door. Nurse #8 further stated she was unsure who was responsible for placing the "Oxygen in use "signage on the resident's rooms entryway. During an interview on 9/25/24 at 11:11 AM, the Director of Nursing (DON), indicated Resident #24 was in a memory unit. The DON further indicated that there was one resident on the unit who removed these signage from the resident's room. The DON stated the nurses was responsible for placing and ensuring the "Oxygen in Use" signage was on the room entryway /door. DON indicated that she would ensure the signage was placed above the door so that the resident could not reach them.	F 695		