STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185131	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Jordan Center	270 E Clayton Lane Louisa, KY 41230

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interview, record review, review of the Postal Service Reform Act of 2022, and review of the facility's policy, the facility failed to ensure residents the right to receive mail, letters, and packages delivered to the facility. In interviews with Resident Council members, they stated they did not receive mail on Saturdays. This practice had the potential to affect all current 92 residents. The findings include: Review of the facility's policy titled, Resident's Rights For Residents in [State] Long-Term Care Facilities, not dated, revealed the resident had a right to exercise his or her rights as a resident of the facility and as a citizen of the United States. Review of the Postal Service Reform Act of 2022 (PSRA) confirmed mandated six-day mail delivery services (Monday through Saturday). In an interview with Resident (R) 71 during the Resident Council meeting on 06/03/2025 at 10:00 AM, the resident stated there was no one to bring mail to residents on Saturdays. In an interview with R12 during the Resident Council meeting on 06/03/2025 at 10:00 AM, she stated she knew of a resident who was waiting on a package on a Saturday, who was told it could not be delivered on Saturday as there was no staff member present to deliver it. In an interview with the Activities Team Leader (ATL) on 06/03/2025 at 3:01 PM, the ATL stated activities staff delivered resident mail, and there were no activities staff working on weekends, although jobs were posted with the plan to fill two more activities vacancies in order to have activities staff present on weekends. The ATL stated there was no one present to deliver mail on Saturdays, and Saturday's mail was not delivered until Mondays when staff was present to pick up and deliver mail. In an interview with the Social Services Director (SSD) on 06/03/2025 at 3:21 PM, she stated mail was held on the weekends at the post office. The SSD stated previously mail was delivered to the facility on weekends, but as there was no staff present to oversee delivery, residents were going through delivered mail. She stated to prevent potential loss, the facility had the post office start holding mail on Saturdays. She stated it had been that way since some time in 2021. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Administrator on 06/05/2025 at 12:35 PM, he stated he was not aware residents were not getting mail on Saturdays. He stated the local post office had stopped delivery due to the pandemic in 2020, and he was not aware that was still in place. The Administrator stated he expected residents to receive uninterrupted mail service.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, record review, and review of the facility's policy, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment, for 1 of 24 sampled residents, Resident (R) 81. R81's Comprehensive Care Plan (CCP) stated his preference for individual activities. It did not, however, reflect any history of service-related, post-traumatic stress disorder (PTSD) potential triggers, or how to address them. The findings include: Review of the facility's policy titled, Care Planning - Interdisciplinary Team, revised 09/2013, stated the facility's Care Planning/Interdisciplinary Team was responsible for the development of an individualized comprehensive care plan (CCP) for each resident. Review of R81's admission Record revealed the facility admitted the resident on 03/26/2025 with diagnoses of end stage renal disease (ESRD), diabetes mellitus, and depression. Review of R81's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 04/07/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of nine of 15, indicating moderate cognitive impairment. No diagnosis of post-traumatic stress disorder (PTSD) was listed. Review of R81's CCP revealed it was initiated on his admission date and most recently updated on 04/15/2025. Per the review, the resident's preference to stay in his room was listed as his activity preference. His treatment of depression and anxiety was documented with pharmacological interventions. No diagnosis of PTSD was listed. Review of R81's Brief Trauma Questionnaire, dated 03/26/2025, revealed two stressful or disturbing events, including military service and a heart attack. The form was not complete and did not address the emotional response or physical injury as a result of the event(s). Review of the facility's document Matrix, dated 06/02/2025, provided to the State Survey Agency (SSA) Surveyors upon survey entry, failed to list PTSD as a diagnosis for R81. Observation on 06/03/2025 at 3:38 PM revealed R81 was sitting in his room. He was in his wheelchair, fully dressed and clean. His affect was pleasant, and he verbally conversed without apparent difficulty. He was watching television and had his cell phone within reach. During an interview on 06/03/2025 at 3:38 PM, R81 stated he preferred activities in his room, he did not like sudden noises, and larger crowds made him uncomfortable. He stated he had service-related PTSD and depression, and he was on medications that helped a little. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/05/2025 at 10:59 AM with the Activities Team Leader, she stated she tried to encourage all the residents to join the group activities or make suggestions of areas they liked. She stated she was aware R81 preferred to have individual activities and preferred to watch movies, so his wife provided an extra online streaming service for him to watch movies and television shows. She stated she received her information about a resident's care from the care plan kept at the nurses' station. She stated she did not participate in any clinical or inter-disciplinary team meetings to discuss updates or concerns. She stated she was not aware of the diagnosis of PTSD and therefore was not aware of specific triggers related to that history. She stated if she had known there were things that made R81 uncomfortable, she could have better planned for those and encouraged him to come out of his room. She stated R81 had told her that he preferred to be alone versus in a crowd and enjoyed movies and television programs. She stated R81's outpatient hemodialysis was scheduled three times a week. During an interview on 06/04/2025 at 10:18 AM with the Minimum Data Set (MDS) Nurse, she stated she was not sure why the diagnosis of PTSD was not on his MDS because she had done a trauma questionnaire with him, which was her responsibility. She stated she was aware this needed to be applied to his MDS assessment. During an interview on 06/05/2025 at 9:00 AM with the Director of Nursing (DON), she stated she was unaware of R81's diagnosis of PTSD. She stated since this information was not available on R81's most recent care plan, dated 04/15/2025, she and the floor staff was likely unaware of any potential triggers. She stated she would follow-up. She stated the harm in not knowing this information would be the lack of prevention of unintended stress or anxiety to the resident. She stated she was aware that R81's preferences included staying in his room and individual versus group activities. She also stated she felt R81's scheduled hemodialysis, three times a week, contributed to his desire not to go out of his room. During an interview on 06/05/2023 at 12:43 PM with the Administrator, he stated it was his expectation that a baseline care plan would be done for all residents, and it would be updated with an intervention as needed. He stated it was important to have this in place so staff would know how best to care for the residents.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, record review, and review of the U.S. Food and Drug Administration's (FDA) guidelines, the facility failed to ensure the resident environment remained as free of accident hazards as was possible to ensure the safety of 1 of 5 residents reviewed for vaping safety. Observation on 06/02/2025 revealed R62 using a vape (e-cigarette) while wearing a nasal cannula that was delivering four liters of oxygen (O2) with R44 exposed to R62's second hand vaping aerosol. The findings include: Review of the facility's policy titled, Electronic Cigarettes Policy [e-cig, vape, vapor pen], undated, revealed the vaping policy did not address oxygen use. Further review revealed there was no provision for the storage of Nicotine liquid (e-juice), and the policy did not address the exposure risk of others to second hand smoke. Review of the U.S. Food and Drug Administration's (FDA) guidelines, Tips to Help Avoid Vape Battery Fires or Explosions, dated 04/12/2024, revealed there could be added dangers, for example, if a vape battery caught fire or exploded near flammable gasses or liquids, such as oxygen. Therefore, per the guidelines, Don't vape around flammable gasses or liquids, such as oxygen, propane, or gasoline. Review of the facility's education to the vaping residents/families provided by the facility revealed it was a copy of an educational handout from the Centers for Disease Control and Prevention (CDC), undated, which was an infographic that was two pages and detailed the dangers of e-cigarettes and vaping. The handout had warnings about nicotine, heavy metals, diacetyl, and other unnamed dangerous chemicals. However, oxygen was not mentioned on the education sheet or any danger paired with oxygen. Review of the facility's document Smokers, updated 06/02/2025, revealed R62 was listed as vapes only. R44 was not on the document. Review of R62's Face Sheet revealed the facility admitted the resident on 10/01/2024 for chronic obstructive pulmonary disease (COPD), chronic kidney disease, and type 2 diabetes mellitus. Review of R62's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 03/31/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 15 out of 15, indicating intact cognition. Review of R62's Comprehensive Care Plan [CCP], initiated 10/01/2024, revealed the resident used vaping daily for pleasure in room. Interventions included to monitor and report any changes in ability to vape; monitor for any safety concerns, potential risks, and resident's ability to safety vape and manage oxygen; and educate as needed on potential risks of smoking/vaping. Review of the facility's document Resident Safe Smoking Assessment for R62, dated 10/03/2024, revealed she vaped in her room, and staff was to monitor for safety concerns and potential risks. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R44's Face Sheet revealed the facility admitted the resident on 08/12/2025 with diagnoses of systemic lupus erythematosus, organ or system involvement unspecified; dysphagia; and type 2 diabetes mellitus Review of R44's quarterly MDS, with an ARD of 04/14/2025, revealed the facility assessed the resident to have a BIMS score of 15 out of 15, indicating intact cognition. Observation on 06/02/2025 at 2:50 PM revealed R62, while in her room, using a vape while wearing a nasal cannula that was delivering four liters of oxygen (O2). R44, who was R62's roommate was present, resting in her own bed in the room. During an interview on 06/04/2025 at 12:35 PM, R62 stated she did not receive education on oxygen and vaping. R62 stated she did use oxygen via the nasal cannula while vaping. The resident stated she had been able to quit cigarettes due to using the vape. In an interview on 06/04/2025 at 12:38 PM, R44 stated she had not been educated on the dangers of second hand smoke from vaping. During an interview on 06/04/2025 at 3:45 PM with Kentucky Medication Aide (KMA) 1, she stated, I thought the rules about O2 use and smoking did not apply to vapes before I was educated on that this morning. I thought the vape would be ok, but I know if I see that occur again, I am to immediately inform the Nurse. During an interview on 06/04/2025 at 3:12 PM with the Director of Nursing (DON), she stated she thought it was okay to vape around oxygen. She stated, while she was not sure of all the dangers of oxygen, she thought the vape was safe with it. She stated, The vape would not alarm me as there is not an open spark or flame. It is safer than a cigarette. During interview with the Administrator on 06/03/2025 at 2:41 PM, he stated a patient should not vape while receiving oxygen. He further stated, As part of their assessment, also in their care plan, we assess them and document that we went through that assessment with each resident. He stated there had been no accidents or incidents in the past year with smoking or vaping.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, review of the facility's daily bedtime snack list, and review of the scientific article referenced by the National Institute of Health (NIH), the facility failed to provide substantial snacks to residents who needed assistance at meals as determined by review of the time between supper and breakfast was greater than 14 hours. Review of the facility meal service times, not dated, revealed total assist residents received supper at 4:30 PM and breakfast at 7:00 AM. The findings include: Review of the scientific article referenced by the National Institute of Health (NIH) in Nutrients titled What is Nutritious Snack Food? A Comparison of Expert and Layperson Assessments? 2017 [DATE]; 9(8):874 revealed the definition of a nutritious snack that contained preferred nutrients was food with a high percentage of essential nutrients relative to the energy content. Observation on 06/04/2025 at 8:10 AM revealed there was no ice cream observed in the [NAME] Unit nourishment refrigerator freezer compartment. Observation of the refrigerator on the [NAME] Unit revealed it had resident food items brought by residents' families, and no other snacks were available. In interviews with Resident Council members on 06/03/2025 at 10:00 AM, they voiced concern that snacks were not offered after the supper meal. They stated snacks were available at the nurses' station, but were not passed. Review of the facility's bedtime snacks, not titled or dated, for general residents without specific snacks, revealed Sunday: Peanut butter cracker 8 oz [ounces] milk, Tuesday: ice cream 4 oz, Thursday: banana bread 8 oz milk, and Saturday: Sherbet 4 oz. Review of the facility's bedtime snacks CCHO HS Snack List [controlled carbohydrate at bedtime], not dated, revealed Sunday: 1/2 c sugar free ice cream; Monday: Meat salad ½ sandwich, 8 ounces of milk; Tuesday: 8 ounces of milk and Sugar free cookies; Wednesday: 1/2 of a turkey, ham, or bologna sandwich with 8 ounces of milk; Thursday: sugar free sherbet; Friday: 2 ounces snack type cheese crackers, flavored water: and Saturday: 4 ounces of sugar free Jello. In an interview with the Dietary Manager on 06/05/2025 at 10:11 AM, she stated the breakfast meal was served at 7:20 AM, and the bedtime snack was taken to the unit at 7:30 PM, which was a substantial snack sandwich and milk. She stated not all total assisted residents received a labeled snack at bedtime. She stated extra sandwiches were sent for the residents each night. She stated each unit nourishment refrigerator contained ice cream, sherbet, cookies, and graham crackers for the residents. In an interview with the Registered Dietitian (RD) and Licensed Dietitian (LD) on 06/05/2025 at 10:49 AM, they stated they assumed residents received or were offered a snack at bedtime. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with Licensed Practical Nurse (LPN) 1 on 06/05/2025 at 11:11 AM, she stated the State Registered Nurse Assistant (SRNA) passed the snacks at night. She stated all residents who did not have a snack labeled with their name were offered a snack. She stated there were no snacks available for residents later at night who were hungry. She stated the nourishment refrigerator freezer had ice cream; however, it was not stocked with sandwiches like they used to do. She stated residents who had an assigned snack received the bedtime snack. She stated residents who could not verbally ask for a snack would receive a snack if they had not eaten well that day. In an interview with the Director of Nursing (DON) on 06/05/2025 at 1:04 PM, she stated snacks were sent out around 7:30 PM, and staff passed them to the residents. She stated specific ordered snacks were labeled with the name of the resident, and extra snacks were available throughout the night. She stated ice cream was located in the freezers on the units. She stated her expectation was for all residents to receive a snack. In an interview with the Administrator on 06/05/2025 at 1:26 PM, he stated the best practice was for all the residents to be offered snacks at night.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, review of the United States Department of Agriculture (USDA) web site, and review of the facility's policies, the facility failed to store and serve food in a safe manner as determined by observations during the initial tour on 05/02/2025. These observations revealed food not labeled or dated in the dry storage, walk-in refrigerator, and the freezer. In addition, observations of the supper meal tray line on 06/02/2025 at 4:16 PM revealed the Dietary Manger and [NAME] improperly used the food thermometer, and Dietary Aide 1 used open utility carts with a wet top shelf. This had the potential to affect 92 residents that received food from the kitchen. The findings include: Review of the facility's policy titled, Food Storage, dated 2010, revealed all stock must be rotated with each new stock received. Per the policy, rotating stock was essential to ensure the freshness and highest quality of all foods. The policy stated old stock was always used first (first in-first out method), and food should be dated as it was placed onto the shelf. Review of the facility's policy titled, Cleaning Instructions: Food Carts, dated 2010, revealed food carts would be cleaned and sanitized immediately after each use. Review of the United Stated Department of Agriculture (USDA) web site https://www.fsis.usda.gov, undated, revealed the food thermometer should be placed in the thickest part of the food, away from bone, fat or gristle. For thin foods, the food thermometer should be inserted through the side until it reached the center of the food. Always check each piece of food to ensure they had reached the safe internal temperature. Observation during the initial kitchen tour with the Dietary Manager on 06/02/2025 at 1:14 PM revealed foods in the walk-in not dated and labeled, such as heads of lettuce, a large bag with mixed peppers, a case of whole tomatoes left open on the bottom shelf, various frozen food items out of the case not dated, and various foods in dry storage out of the case not dated. Observation of the Dietary Manager on 06/02/2025 at 4:16 PM during the supper meal tray line revealed she pushed the food thermometers through the plastic wrap of the food on the steam table. The [NAME] on 06/02/2025 at 4:26 PM stated the steam table is so hot it melted the plastic as she tried to read the thermometer in the plastic wrap. Continued observation of the Dietary Aide on 06/02/2025 at 4:20 PM revealed she pushed two utility carts with wet top shelves to the other side of the tray line. Observation of the Dietary Aide revealed she placed the food trays onto the wet top shelf of the utility cart going to the [NAME] Unit at 4:36 PM. In an interview with the Dietary Manager on 06/04/2025 at 8:55 AM, she stated to not pierce food with the thermometer through the plastic wrap or foil because there was a potential for cross contamination. She stated all foods should be labeled and dated and food rotated first in and first out (FIFO) to prevent the risk of bacterial growth. In an interview with the [NAME] on 06/05/2025 at 10:31 AM, she stated the proper way to take the food temperature was by pulling back the plastic or foil covering the food. She stated this would prevent the potential cross contamination of the food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with the Director of Nursing (DON) on 06/05/2025 at 1:09 PM, she stated her expectation was for staff to follow best practices for the food service. In an interview with the Administrator on 06/05/2025 at 1:28 PM, he stated his expectation was for staff to follow best practices for food service.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, review of the manufacturers' directions for use (DFU), and review of the facility's policies, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 24 sampled residents, Resident (R) 46. Observation on 06/03/2025 revealed R46's tube feeding, tubing, and continuous bladder irrigation tubing were left uncovered when disconnected from the resident. The findings include: Review of the facility's policy titled, Infection Control Program, last review date 08/24/2024, revealed the primary purpose of the facility's infection control program policies and procedures was to establish guidelines to follow to provide a safe and sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. It also stated it was the responsibility of the process improvement (PI) committee, through the Infection Control Preventionist, to ensure that infection control policies and procedures were implemented and followed. Review of the facility's policy titled, Enteral Nutrition, last review date 01/2014, revealed that staff caring for residents with feeding tubes would be trained on the potential adverse effects of tube feeding, such as feeding tube associated complications. Review of the manufacturer's DFU for the [Brand Name] of the tube feeding set with a 1000 milliliter (mL) flush bag, revealed it included a protective cap at the end of the tubing for use when the tubing was disconnected from the resident. Review of the manufacturer's DFU, provided by the facility, for the [Brand Name] Intravenous Administration Set, lot number 186249KS, used in R46's continuous bladder irrigation (CBI), revealed it had a tip protector on each end of the tubing for the protection of the tubing when not in use. Observation on 06/03/2025 at 9:58 AM, revealed R46 was out of her room and both, the tube from her tube feeding and the intravenous (IV) tubing from her CBI, were left connected to the source and with the other end, intended for the resident, open to air and without appropriate covering. During an interview on 06/02/2025 at 3:15 PM with Registered Nurse (RN) 2, she stated she was the nurse for R46, and she was unaware of a specific cover for the tube-feeding or the IV tubing. RN2 stated she was unsure if those were available but acknowledged that some type of covering should have been placed on both tubes. She stated by leaving the ends open and uncovered, they could be exposed to germs and could cause the resident to become ill. She stated she was provided Infection Control training at the facility, in person, by the Infection Preventionist (IP), but she could not recall the date. After the interview, RN2 removed the tubing from the room and subsequently hung new tubing with caps. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/04/2025 at 9:37 AM with the Infection Preventionist Nurse, she stated it was her expectation that staff would follow the policies of the facility. She stated the concern for leaving the tubing without an appropriate covering was an increased risk for infection to the resident. She stated she provided education to staff initially upon employment and again monthly and as needed. During an interview on 06/05/2025 at 10:45 AM with the Director of Nursing (DON), she stated it was her expectation that staff would follow the facility's infection control policies. She stated the concern of leaving the tubing uncovered was the increased risk of infection for the resident. During an interview on 06/05/2025 at 12:43 PM with the Administrator, he stated he expected the staff to follow regulatory guidelines and facility policy regarding infection control.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185131	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Jordan Center	270 E Clayton Lane Louisa, KY 41230

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. Based on observation, interview, review of a Centers for Disease Control and Prevention (CDC) document, and review of the facility's policy, the facility failed to develop and implement effective policies to ensure the smoking safety for all residents that used electronic cigarettes (e-cigarettes or vapes) for 1 of 5 residents that used e-cigarettes, Resident (R) 62 and R44, who was exposed to R62's second hand vaping aerosol. Observation on 06/02/2025 at 2:50 PM revealed R62, with R44 present, using a vape while wearing a nasal canula that was delivering four liters of oxygen (O2), and the facility's vaping policy did not address oxygen use or the exposure risk of others to second hand smoke. Refer to F689 The findings include: Review of the facility's policy titled, Electronic Cigarettes Policy [e-cig, vape, vapor pen], undated, revealed the vaping policy did not address oxygen use. Further review revealed there was no provision for the storage of Nicotine liquid (e-juice), and the policy did not address the exposure risk of others to second hand smoke. Review of a CDC document About E-Cigarettes (Vapes), dated 10/24/2024, revealed e-cigarettes or vapes were battery operated devices that heated a liquid and produced an aerosol that released particles in the air, known as vapor. It stated that bystanders could also breathe in the aerosol from what the smoker breathed out. Per the document, e-cigarettes typically contained nicotine, a very addictive substance. It also stated the aerosol was not harmless and could contain cancer-causing chemicals; heavy metals such as nickel, tin, and lead; tiny particles that could be inhaled deep into the lungs; and volatile organic compounds. Review of the U.S. Food and Drug Administration's (FDA) guidelines, Tips to Help Avoid Vape Battery Fires or Explosions, dated 04/12/2024, revealed there could be added dangers, for example, if a vape battery caught fire or exploded near flammable gasses or liquids, such as oxygen. Therefore, per the guidelines, Don't vape around flammable gasses or liquids, such as oxygen, propane, or gasoline. Observation on 06/02/2025 at 2:50 PM revealed R62, while in her room, using a vape while wearing a nasal cannula that was delivering four liters of oxygen (O2). R44, who was R62's roommate was present, resting in her own bed in the room. During an interview on 06/04/2025 at 12:35 PM, R62 stated she did not receive education on oxygen and vaping. R62 stated she did use oxygen via the nasal cannula while vaping. During an interview on 06/04/2025 at 12:38 PM, R44 stated she did not smoke or vape and had not been educated on the dangers of second hand smoke from vaping. During an interview with Registered Nurse (RN) 2 on 06/04/2025 at 3:50 PM, she stated, We have not really been educated about vapes when used with oxygen. In the outside world we see the vapes being used everywhere and you really don't think about it. But here if you stop and think about it, maybe we should look into updating our policies. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185131	A. Building B. Wing	06/05/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 06/04/2025 at 3:12 PM, she stated that while she was not sure of all the dangers of oxygen but thought the vape was safe with it. She stated, The vape would not alarm me as there is not an open spark or flame. It is safer than a cigarette. The DON stated she was part of the policy drafting meetings. She stated they did not discuss second hand exposure to other residents and the healthcare workers. She stated, Most of our workers vape themselves. Going forward we will be more thorough with our assessments. We will update the policy to include no oxygen with use, and more monitoring. During an interview with the Administrator on 06/03/2025 at 2:41 PM, he stated he was unaware of a resident using a vape while on 02, but that should not occur. During an interview with the Medical Director on 06/03/2025 at 3:58 PM, he stated he had not had any instances of treating anyone who had been injured or became sick from the use of the vape. He stated he felt it was a safer alternative to cigarettes. The Medical Director stated, As I examine patients at [the facility], there has been no evidence of anyone suffering significant harm from second hand smoke. If it didn't cause an enormous disruption, I would prefer the nicotine liquid to be kept at the nursing station because misuse instead of intended use would be more of a risk. I would be open to information from staff as to keeping liquid for vapes. It could be overkill to keep at the nurses' station, or less potential for harm. He did not address the issue of a patient on O2 and vaping.