STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235619	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Church of Christ Care Center	23575 15 Mile Rd Clinton Township, MI 48035

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 1238200.Based on interview and record review the facility failed to utilize the required two staff to complete incontinence care for one sampled resident (R4) of four residents reviewed for accidents, resulting in a fall from the bed and a fracture of the right arm. Findings include:During a closed record review of R4's medical record it was noted that R4 was transferred to the hospital after a fall during care. A review of R4's medical record progress notes revealed, 8/17/25 -Writer called to room by nurse assistance. Res (resident) observed on floor, lying on right side. Lying next to bed closest to the window. Nightstand and bed side table next to [R4], close to [R4's] head. Res is alert and verbal. Verbal complaints of pain to right side. Physician in house. Assessed at bedside while on floor. Order received to send to ER (Emergency Room) via 911. Res kept in same position. No active bleeding noted at this time. Awaiting EMT's (Emergency Medical Technicians).Further review revealed, 8/17/25 -Physician Progress Note: Patient was seen today per nursing request due to the above-mentioned concern. No fever or chills no chest pain or SOB (Shortness of Breath) no abdominal pain no headache. Patient fell out of bed during care, [R4] landed on [R4's] right side, [R4] reported that [R4] struck [their] head against on the floor. [R4] is on Eliquis (blood thinner) due to a history of A-Fib. [R4] complains of pain over right arm and wrist. No LOC (Loss of Consciousness). [R4] complains of pain over right arm and wrist. Assessment and plan; 1. S/P (status post) fall on Eliquis 2. Closed head injury, no LOC 3. Paroxysmal atrial fibrillation; on Eliquis 4. Morbid obesity 5. Old CVA (cerebrovascular accident) with right hemiparesis 6. Debility; continue supportive care 7. Plan of care was discussed with nursing Call 911 and transfer patient. to ER for further evaluation and treatment. A continued review of R4's medical record revealed that R4 was admitted to the facility on [DATE], readmitted on [DATE], and discharged [DATE]. A review of R6's Minimum Data Set quarterly assessment dated , 7/3/25 noted R4 with an intact cognition.A review of R4's care plan revealed, . Focus: Self Care Deficit r/t (related to) Physical Weakness, poor endurance, bilateral cataracts, right hemiparesis, and impaired mobility. Goal: Resident Care needs will be met daily. Interventions: Bathing: I am dependent on 2 staff members to provide for my bathing needs. Dressing: I require extensive assistance of 2 staff to assist me with dressing. I am incontinent of bowel and bladder and require total assistance of 2 staff to provide incontinence care. Bed Mobility: I require extensive assistance of 2 staff member and my right-side enabler bar for bed mobility.Toileting Provide extensive assistance with personal hygiene care: nails, hair, oral care, bathing. PHO Care: I am incontinent of bowel and bladder and require total assistance of 2 staff to provide incontinence care. BED MOBILITY: I require extensive assistance of 2 staff member and my right side enabler bar for bed mobility. On 8/20/2025 at 1:18 PM, the Director of Nursing (DON), called R4 at the hospital for an interview regarding the fall. R4 explained they were being assisted by Certified Nursing Assistant (CNA) N to get ready for the day. R4 explained CNA N was the only CNA in the room. R4 continued and explained, they were rolled on to their side and CNA N turned to get the cream for their bottom and that is when they rolled out of bed. R4 stated they hit their head, and their arm was in pain after the fall and was transferred to the hospital.The DON was asked their (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 0689 Level of Harm - Actual harm Residents Affected - Few	expectations for following the care plan. The DON explained, staff is to follow the minimum number for staff assistance and to follow the Kardex (CNA care guide). The DON confirmed R4 stated they had an Acute proximal humerus fracture of the right arm. On 8/20/2025 at 3:56 PM, CNA N was asked via phone about the fall with R4. CNA N explained it was during care they asked R4 to grab the bar to turn to the side, because they had a small bowel movement. CNA N explained they had turned their back to get the cream and that is when R4 fell out the bed. CNA N was asked if they knew R4 was a two person assist for ADLs. CNA N confirmed they did know but was unable to locate another staff person to help at that time. A review of the facility's policy titled, Fall prevention Program dated, 2/5/22, noted Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Policy Explanation and Compliance Guidelines .3. Interventions will be implemented by the care team.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to have available and don/doff (put on and take off) personal protective equipment (PPE-gowns, gloves, masks, etc.) for one resident on Enhanced Barrier Precautions (EBP) (R117) out of six reviewed for infection control. Findings include:R117On 8/19/2025 at 2:00PM, R117's door was observed with a sign stating the room was on Enhanced Barrier Precautions (EBP). No PPE was observed on the door, or in the room.On 8/19/2025 at 2:08 PM, Certified Nursing Assistant (CNA) J was observed going into R117's room and provided care to R117 and their roommate, both were on EBP. CNA J was noted to have on gloves and a mask. CNA J was asked if they put on a gown while providing care. CNA J reported they did not put on a gown and that there was not one available.On 8/20/2025 at 11:00 AM, an infection control meeting was held with the Director of Nursing (DON). The DON reported they completed EBP training earlier in the year and they have been facing some challenges since changes in staffing. A review of a facility policy titled, Enhanced Barrier Precautions noted the following, .3. Implementation of Enhanced Barrier Precautions: Make gowns and gloves available immediately near or upon entrance into the resident's room.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to ensure the ice machine near the main kitchen was backflow protected. This deficient practice had the potential to affect all residents in the facility. Findings include: On 08/18/2025 at 11:45 AM, the ice machine drain line was observed to extend down inside the floor drain. There was no air gap between the bottom of the drain line pipe and the flood rim of the floor drain. Dietary Manager O confirmed the lack of an air gap and stated she would let Maintenance know. According to the Food & Drug Administration (FDA) 2022 Model Food Code, Section 5-402.11 Backflow Prevention, (A) Except as specified in (B), (C), and (D) of this section, a direct connection may not exist between the sewage system and a drain originating from equipment in which food, portable equipment, or utensils are placed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop/implement comprehensive care plans for three residents (R13, R88, and R99) out of four reviewed for Care Plans. Findings Include:R13 On 8/18/25 at 9:00 AM, R13 was observed sitting on the side of the bed. R13 appeared anxious with nervous speech and finger movements. A review of the medical record for R13 occurred and revealed the following: R13 was initially admitted to the facility on [DATE] and after a brief hospitalization was readmitted [DATE] with following diagnoses including: Dementia, Schizophrenia, Depression and Chronic Obstruction Pulmonary Disease. A review of R13's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental status (BIMS) assessment score of 14/15 indicating intact cognition. Further review of R13's medical record revealed a care plan for antipsychotic medications and an intervention noted was for staff to monitor behaviors. Care plan interventions documented Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. On 08/19/2025 at 2:00 PM a request was made for R13's behavior monitoring log. On 8/20/25 at 2:45 PM, the Director of Nursing (DON) was interviewed. The DON stated that there was no monitoring tool for behaviors for R13. When asked what their expectation for residents and behavior monitoring. The DON replied, My expectation is that residents on psychotropics will be monitored for care plan per policy. On 8/20/25 a review of the Comprehensive Care Plan Policy dated 10/28/2022 revealed, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. R88 On 8/18/2025 at 12:48 PM, R88 was observed in their room. R88 was observed to be bending down and fixing the covers on their bed and their wheelchair behind them. R88's wheelchair was noted to be unlocked and moved when R88 sat back down in their chair. A review of the medical record revealed that R88 was admitted into the facility on 2/22/2021 with the following medical diagnoses, Dementia and a Fall. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 2/15 indicating an impaired cognition. R88 also required assistance with bed mobility and transfers. A review of an Incident and Accident (I/A) report revealed that R88 had a fall on 2/18/2025. The I/A reported that R88 was observed sitting behind facing the door next to their wheelchair. R88 reported they were trying to get into their wheelchair. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the fall care plan revealed an active intervention for anti-roll backs to wheelchair dated 3/11/2025. On 8/19/2025 at 10:47 AM, R88 was in their room and had just returned from therapy. No anti-roll backs were observed on the wheelchair. On 8/20/2025 at 9:22 AM, R88 was observed in their room. R88 was out of their wheelchair and bending over, attempting to fix the covers on their bed. R88 wheelchair was not locked. Occupational Therapist (OT) D was asked if R88 had anti-roll backs on their wheelchair. OT D reported R88 did not have them on their chair and that they probably needed them. OT D then was observed asking R88 to sit down and locked R88's wheelchair. OT D reported they were going to make a note of it and get them in the right chair. On 8/20/2025 at 12:18 PM, an interview was completed with the Director of Nursing (DON). The DON reported R88 will have the anti-roll backs put on their chair today. The DON reported that the intervention was put in, however there is still a process, and it has to be put in the system for maintenance to install them on the wheelchair. The DON reported it has to be communicated properly. R99 On 8/18/2025 at 12:34 PM, R99 was observed in their room. R99 was tearful and stated that they get sad and depressed sometimes in the facility. R99 reported they are seen by the psychologist in the facility and that helps with their mood. A review of the medical record revealed that R99 admitted into the facility on 8/16/2024 with the following medical diagnoses, Muscle Weakness and Bi-Polar Disorder. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 15/15 indicating an intact cognition. R99 also required assistance with bed mobility and transfers. Further review of a note from the Psychiatry group dated 3/5/2025 listed Post-Traumatic Stress Disorder (PTSD) as a current, chronic, and unchanged diagnosis for R99. Further review of R99's care plans revealed that R99 did not have a care plan addressing their PTSD diagnosis. On 8/19/2025 at 9:44 AM, an interview was conducted with Social Service Director (SSD) C. SSD C reported it was brought to their attention that R99 did not have an PTSD care plan, and they entered one. SSD C reported they will be following up with psychiatrist to ensure it is an accurate diagnosis as well.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to complete an accurate resident assessment for one sampled resident (R36) of 23 reviewed for assessments. Findings include:On 8/18/25 at 9:17 AM, R36 was observed in their bed and asked if they had a pressure ulcer. R36 replied, Yes.On 8/19/2025 at 10:13 AM, an observation of R36's skin was completed with a nurse and a Physician. R36's skin was observed with a rash that started from the middle of their back to the back of R36's legs. R36's skin was observed to no longer have a pressure ulcer.A review of R36's medical record noted R36 was admitted to the facility on [DATE] with a diagnosis of Chronic Respiratory failure. A review of R36's Minimum Data Set (MDS) annual assessment dated [DATE], noted R36 with a moderately impaired cognition and R36 required assistance by staff to complete activities of daily living. Further review of R36's MDS noted, that R36 had one unhealed stage two pressure ulcer (characterized by a partial thickness loss of skin, meaning the outer layer (epidermis and part of the inner layer-dermis are damaged), a pressure reducing device for bed, and chair.A review of R36's progress note dated 5/12/25 revealed, .Patient seen for: stage 2 left ischium. Patient seen per nursing staff request for the above concern. staff reports patient has developed a stage 2 area to left ischium. Upon assessment today, area has resolved along with abrasion to scrotum . Skin; intact, rash and scabs remain allover body . Assessment and Plan; Stage 2 pressure injury; Resolved as of today. Apply house barrier cream and report any changes to MD (medical doctor) . Plan of care discussed with nursing staff.On 8/20/2025 at 10:06 AM, MDS Nurse F was interviewed via phone and informed that on the 7/30/25 MDS R36 is marked as having a current unhealed stage two pressure ulcer, when it was noted as healed on 5/12/2025. MDS Nurse F explained, they would have to speak with the other MDS Nurse because they did not complete the assessment for R36. A review of the facility policy titled, MDS Completion dated, 3/12/25 noted, Policy: Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan. Policy Explanation and Compliance Guidelines: 1. According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI (Resident Assessment Instrument) specified by the State .

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, interview, and record review, the facility failed to provide built up utensils for one resident (R99) out of one reviewed for Adaptive Equipment. Findings include:On 8/18/2025 at 9:25 AM, R99 was observed eating breakfast. R99's meal ticket was noted to have a note stating built up utensils highlighted in blue. R99 was observed eating with regular utensils. R99 stated they rarely get the right utensils, and that the built-up utensils really help them with their meals and the pain they have in their hands.A review of the medical record revealed that R99 admitted into the facility on 8/16/2024 with the following medical diagnoses, Muscle Weakness and Bi-Polar Disorder. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 15/15 indicating an intact cognition. R99 also required assistance with bed mobility and transfers. On 8/18/2025 at 9:30 AM, Occupational Therapist (OT) E was shown R99's meal ticket and the regular utensils. OT E reported R99 should have built up utensils and they will have to check with the kitchen to see why they were given regular utensils.On 8/20/2025 at 10:19 AM, an interview was completed with Registered Dietitian (RD) D. RD D reported R99 still required their built-up utensils and would follow up on why they did not receive them.On 8/20/2025 at 12:20 PM, an interview was conducted with the Director of Nursing (DON). The DON reported they would speak with dietary to see why they did not receive their built-up utensils. The DON reported R99 eats in their room and should have them on the tray. A review of a facility policy titled, Activities of Daily Living noted the following, .1.The facility will support resident autonomy in the performance of ADLs consistent with their physical and cognitive abilities.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 1238202.Based on observation, interview, and record review, the facility failed to provide 1:1 feeding assistance for one resident (R16) and grooming assistance for one resident (R20) out of three reviewed for Activities of Daily Living (ADL). Findings include:R16 On 8/18/2025 at 10:44 AM, R16 was observed in bed. R16 was noted to be sitting with the head of bed (HOB) elevated and a clothing protector on. The bedside table was pulled over them and their breakfast tray was sitting in front of them. R16 was noted to have a hash brown and eggs on their clothing protector and eggs on their face. R16 was observed attempting to pick up their eggs with their fingers. The meal ticket was noted to have 1:1 assistance and highlighted in yellow. A review of the medical record revealed that R16 was admitted into the facility on 1/6/2022 with the following diagnoses, Cerebrovascular Disease and Alzheimer's Disease. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 0/15 indicating an impaired cognition. R16 also required assistance with bed mobility and transfers. Further review of the physician’s orders revealed an active order dated 5/15/2025 for 1:1 assistance with feeding. On 8/18/2025 at 1:17 PM and 1:30 PM, R16 was observed in their room with their lunch tray in front of them. No one was observed in the room assisting R16 with eating. R16 was observed with chicken and green beans on their clothing protector and chin. On 8/20/2025 at 9:19 AM, Certified Nursing Assistant (CNA) “A” was asked if R16 requires assistance with feeding. CNA “A” reported R16 does better in the dining room, but if they are in the room then they need assistance and encouragement to eat. On 8/20/2025 at 9:35 AM, an interview was conducted with Registered Dietitian (RD) “B”. RD “B” reported R16 needs more assistance with their meals, and it can sometimes take them a while to get warmed up. On 8/20/2025 at 12:16 PM, an interview was conducted with the Director of Nursing (DON). The DON reported that if a resident requires feeding assistance, then they should be fed and get the help that they need. R20 On 08/18/2025 at 9:41 AM, R20 was observed sitting in their wheelchair in the hallway. They were observed to have facial stubble that appeared to be unshaven for approximately three to four days. Review of the facility record for R20 revealed they were admitted into the facility on [DATE] with diagnoses including Hypertensive Heart Disease with Heart Failure and Mood Disorder with Depressive Features. Due to the limited time since admission, R20's Minimum Data Set (MDS) information was not available however the resident's baseline care plan indicated they required one-person assistance for self-care tasks. On 08/20/2025 at 1:09 PM, R20 was observed during an interview to continue to have longer facial (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stubble unshaven since the 08/18/2025 observation. They were asked if they preferred to have their facial hair growing out or to be cleanly shaven and they reported they preferred to stay clean shaven but they have trouble doing it themselves. They were asked if the staff assist them to shave and they stated They have but not very often. On 08/20/2025 at 1:23 PM, Certified Nursing Assistant (CNA) K reported they had provided care for R20 on a regular basis. CNA K was asked if they assist R20 to shave and they reported A male aide shaves [R20] on their shower days twice a week. On 08/20/2025 at 1:31 PM, the facility Director of Nursing (DON) reported that being shaved on shower days is the current facility protocol unless requested otherwise by the resident. The DON was asked if resident's preference for frequency of shaving is assessed upon admission and they reported the preference for frequency of shaving is not specifically addressed during establishment of the care plan. Review of the facility policy titled Activities of Daily Living dated 08/03/20 revealed the policy statements 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene .4. The resident's needs and care approaches will be updated in the care plan and reviewed on an as needed basis.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to reposition one resident (R113) in a timely manner out of two reviewed for interventions for pressure ulcers. Findings include:On 08/18/2025 at 9:56 AM, 12:25 PM, and 4:05 PM, R113 was observed lying on their back in bed with arms down on sides. The head of the bed was elevated to 40 degrees. R113 was on an air mattress, wearing a hospital gown with heel boots on. On 08/19/2025 at 10:01 AM, observed R113's family in room providing mouth care, and grooming for R113. The family member stated they were at the facility for a care conference and expressed concerns that since R113 returned from the hospital, the resident has not been talking, and staff are not assisting R113 to get out of bed. On 08/19/2025 at 12:12 PM, 1:59 PM, and 3:43 PM, observed R113 lying on their in bed with wedge cushion slightly under left hand. The head of the bed was elevated to 40 degrees. R113 was on an air mattress, wearing a hospital gown with heel boots on. A review of the medical record for R113 revealed R113 was admitted into the facility on [DATE]. Diagnoses included High Blood Pressure, Urinary Tract Infection, and Muscle Weakness. A review of the Minimum Data Set assessment dated [DATE], revealed R113 was dependent relying on staff for Activities of Daily Living (ADLS) including bed mobility. A review of admission nursing assessment dated [DATE], R113 was admitted into the facility with a Stage 2 (top layer of the skin is open and red in color) Pressure wound on his buttocks. A care plan dated 05/27/2025 indicated resident is at risk for skin breakdown.On 08/19/2025 at 11:07 AM, Certified Nursing Assistant (CNA) I was asked about how often dependent residents are repositioned. The CNA stated, every 2 hours or as needed. On 08/20/2025 at 1:26 PM, an interview with Wound Care Nurse/Licensed Practical Nurse (LPN) G was asked what interventions were in place for R113 related to repositioning for wound care. LPN G revealed turning and repositioned as needed, elevating heels in bed as tolerated, and a pressure reducing mattress (bed that floats). LPN G further explained that the expectations for R113 would be for the CNAs to reposition R113 throughout the day, at least every two hours or more often, due to the presence of a wound, even though a pressure-reducing mattress is in use. On 08/20/2025 at 2:00 PM, in an interview with the Director of Nursing (DON) they were queried regarding what are the expectations of repositioning residents to which they confirmed, every two hours or more if needed. for wound care. A review of the Policy titled Turning and repositioning dated 05/17/2022, revealed turning and repositioning as part of our systematic approach to pressure injury prevention and management. A turn schedule includes using both side-lying and back positions, alternating from the right, back and left side.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235619	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Church of Christ Care Center	23575 15 Mile Rd Clinton Township, MI 48035

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and record review the facility failed to apply oxygen per physician order for one resident (17) out of 2 reviewed for respiratory care. Findings include.On 08/18/2025 at 9:01 AM, and 12:05 PM, R17 was observed sitting on the side of the bed without oxygen in use. The oxygen concentrator was on, and the tubing was lying on the floor by the bedside. On 08/19/2025 at 7:15 AM, R17 was observed sitting at the side of the bed without oxygen in use. The oxygen concentrator was on, and the tubing wrapped around concentrator. On 08/19/2025 at 9:56 AM, R17 was observed leaving the facility with a family member and no oxygen in use.On 08/19/2025 at 10:15 AM, during an interview with Registered Nurse (RN) M regarding oxygen for R17, RN M replied, I think [R17] oxygen is ordered as needed, I do believe. A review of the medical record for R17 revealed R17 was admitted into the facility 03/15/2024 with diagnoses included Respiratory Failure, Chronic Kidney Disease, and Congestive Heart Failure. R17 was admitted to the facility with an order dated 03/15/2024 for continuous oxygen at four liters per minute via nasal cannula. A review of R17's care plan noted, Focus: R17 has Oxygen Therapy related to shortness of breath when needed, history of respiratory failure Date Initiated: 02/04/2020. Goal: for R17 will have no signs or symptoms of poor oxygen absorption through the review date. Date Initiated: 06/16/2020 Provide oxygen in the following manner: cannula continuous Date Initiated: 06/16/2020. On 08/20/2025 at 1:57 PM, an interview was conducted with the Director of Nursing (DON) regarding the expectations for oxygen therapy orders. The DON replied that when a physician orders oxygen at a set liter flow continuously and a resident is not wearing it, nurses are expected to repeatedly encourage resident to use the oxygen as ordered and monitor oxygen saturation (Spo2) closely, and notify the physician of the noncompliance and discuss the possibility of changing to PRN (as needed) or trialing discontinuation of oxygen.