STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345089	A. Building B. Wing	07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Walnut Cove Health and Rehabilitation Center	511 Windmill Street Walnut Cove, NC 27052

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20670 Based on observations, record reviews, residents and staff interviews, the facility failed to honor 1 resident (Resident #30) of 2 residents reviewed for safe smoking the right to take smoking breaks at their preferred times. Findings included: Resident #30 was admitted to the facility on [DATE]. Review of the facility's Smoking Evaluation dated 5/22/24 indicated Resident #30 was alert, oriented and could consistently perform safe smoking techniques. The resident demonstrated fine motor skills needed to light a cigarette safely with a lighter, securely hold a cigarette, and was able to communicate the risks associated with smoking. The facility assessed Resident #30 as a safe smoker. The care plan dated 5/28/24 revealed Resident #30 was educated on the facility's smoking policies and was able to verbalize smoking safety. Interventions included: the resident will smoke during designated smoking times; and required constant supervision while smoking. The quarterly minimum data set (MDS) dated [DATE] indicated Resident #30 was cognitively intact. A review of the facility's smoking schedule indicated residents who smoked were allowed to smoke in the designated area on the facility's compound at 9:00 a.m., 2:00 p.m., and 9:00 p.m. with staff supervision. During an interview on 6/23/24 at 1:50 p.m., Resident #30 revealed he was only allowed to smoke at the facility three times each day per the smoking schedule and supervised by facility staff. During an interview on 6/26/24 at 10:43 a.m., the Maintenance Director stated Resident #30 was a safe smoker; had never dropped cigarettes or burned his clothing or skin while smoking. He further revealed that if a resident requested to be escorted to the designated smoke area and it was not during the scheduled smoke time, he would refuse because he would have to supervise the resident, and he could get in trouble. He did not differentiate between safe & unsafe smokers. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/24 at 4:18 p.m., the Executive Director stated that according to the smoking assessments, Resident #30 was an unsafe smoker but did not provide a reason as to why he as an unsafe smoker. She indicated that she would meet with the interdisciplinary team to discuss changing the process to allow residents deemed safe smokers the opportunity to smoke independently during times of their choosing.

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. 48945 Based on record review and staff interviews the employee file was missing evidence of pre-employment screening documents for history of abuse, neglect, exploitation, or misappropriation of residents on a staff reviewed for allegation of staff to resident abuse (Nurse Aide #1). The findings included: The facility's policy on abuse, neglect, exploitation and misappropriation dated 11/30/14 and revised on 11/16/22 was reviewed during the survey. The screening paragraph stated persons applying for employment will be screened for a history of neglect, exploitation, or misappropriation of resident property. This includes but not limited to employment history, criminal background checks, abuse check with appropriate licensing board and registries prior to hire, sworn disclosure statement prior to hire, licensure or registration verification prior to hire, documentation of status of any disciplinary actions form licensing or registration boards and other registries, information from former employees. Review of NA #1's employee file revealed he was hired by the facility on 9/4/19. The employee file had orientation documents. There were no pre-employment screening documents in the employee file. During a discussion on 6/25/24 at 12:01 pm, the Executive Director stated they have looked everywhere for NA #1's pre-employment screening documents but could not find them. She stated there was a high turnover with the Human Resources (HR) job and the files may have been misplaced. The Executive Director stated they would keep searching for NA #1's file. During a follow up discussion on 6/26/24 at 11:22 am, the Executive Director stated they still could not find NA #1's files. She stated she asked NA #1 to sign a consent for a criminal background check on 6/25/24. She stated she did not allow him to work starting 6/25/24 until the facility receives the criminal background check. The Executive Director stated the new HR staff started conducting audits of all the facility employees' files.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48945 Based on record review and staff interviews, the facility failed to report an initial allegation of staff to resident abuse to Adult Protective Services (APS) for 1 of 5 residents reviewed for abuse (Resident #71). The findings included: A review of the facility's Abuse, Neglect, Exploitation and Misappropriation policy, last revised 11/16/22, revealed the Administrator ensured the reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations. Resident #71 was admitted on [DATE]. The facility's Executive Director completed an Initial Allegation Report to the State Agency on 6/16/24. The report designated the type of allegation as Resident Abuse and indicated the facility became aware of the allegation on 6/16/24 at 6:15 pm. Allegation details revealed Nurse Aide #1 (NA) was rough to Resident #71 when assisting him back to bed that morning on 6/16/24. The facsimile receipt provided by the facility was dated and timed as 6/16/24 at 8:11pm when the report was faxed to the State Agency. Further review of the report indicated APS was not notified of the allegation of abuse. During an interview on 6/25/24 at 11:28 AM, the Assistant Director of Nursing (ADON) stated she was in front the Resident # 71's room when his roommate made the allegation to her on 6/16/24. She stated she could not remember the time, but it was close to lunch time. Resident #71's family member was also present in the room when his roommate said Resident #71 was thrown against the wall by NA #1 that morning. She stated she immediately reported it to the Executive Director around noon but did not know the specifics of the allegation since the resident could not verbalize what happened. The ADON stated she called NA #1 and the night nurse to come back and write a statement. She stated she assessed Resident #1 and completed a skin check. She did not see any injuries or bruises. Both staff told her the incident happened around 5:30 am and both staff were present. The ADON stated both staff heard the roommate yelling for help and observed Resident #71 standing beside his roommate's bed. The resident was unsteady on his feet and was holding on to the bedside table so both staff assisted him to the floor then back to his bed. Both staff wrote statements and they both denied the resident was thrown against the wall. During an interview on 6/25/24 at 9:35 am, the Executive Director revealed the Assistant Director of Nursing (ADON) notified her close to dinner time. The ADON told her that Resident #71's roommate told her that NA #1 threw Resident #71 against the wall. The Executive Director stated she went to talk to Resident #71's roommate and the roommate reported that NA #1 threw Resident #71 against the wall. She stated the resident did not have injuries or bruises when the ADON assessed the resident. The nurse was assisting NA #1 during the incident and wrote a statement that the allegation did not occur. The nurse reported that NA #1 did not throw resident against the wall. The Executive Director stated she did not notify APS. She stated she thought she did not need to since the resident was safe and was in the facility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a discussion on 6/26/24 at 5:15 pm with the Corporate Consultant and Executive Director, the Corporate Consultant stated she remembered the requirement to notify APS on 6/17/24 and discussed this with the Executive Director. The Executive Director revealed she did not notify APS about the abuse allegation. She stated that she thought the resident was safe in the facility and did not think to report it. The Corporate Consultant asked the Executive Director to notify APS via email during the discussion on 6/26/24.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 45276 Based on observation, record review, staff and resident interviews and a life safety surveyor interview the facility failed to ensure the safety of residents in the designated smoking area of the facility when a staff member supervising the residents who smoked lit Resident #78's cigarette and allowed the resident to smoke with a combustible tank of compressed oxygen attached to the back of her wheelchair while she sat in the wheelchair. Residents who were also smoking were seated near the oxygen tank. The oxygen tank was turned off while the residents smoked. Even if turned off, it is not safe to smoke around an oxygen tank, oxygen-enriched levels can remain on tubing, clothing, hair, and skin increasing the risk for fire and/or explosion. Supplemental oxygen can make fires burn faster and hotter. This practice was for 1 of 8 sampled residents but placed 7 additional residents at risk for the high likelihood of serious injury or harm. Immediate jeopardy began on 6/26/24 when a staff member lit Resident #78's cigarette with an oxygen tank attached to her wheelchair. The immediate jeopardy was removed on 06/27/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of E (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems are put in place and to complete employee in-service training. The findings included: Resident #78 was readmitted to the facility on [DATE]. Her diagnoses included chronic obstructive pulmonary disease. Review of Resident #78's physician's orders dated 04/10/24 included an order for continuous oxygen at 3.5 liters via nasal canula. Resident #78's smoking evaluation dated 04/10/24 revealed the Resident was a smoker and was able to communicate why oxygen must always be shut off prior to lighting cigarettes. Resident #78 was not able to light cigarettes safely with a lighter. Resident #78 was marked as smokes safely (Does not allow ashes or lit material to fall while smoking, inhaling or holding smoking item. Remains alert and aware while smoking. Does not forget he/she is smoking or falls asleep holding item. Does not endanger self or others while smoking. Does not burn furniture, clothing, skin, self, or others. Turns oxygen off prior to lighting cigarette. Smokes only in designated area). The summary of the evaluation revealed resident was marked as required supervision while smoking. Review of Resident #78's admission Minimum Data Set (MDS) dated [DATE] revealed she had moderate cognitive impairment and was on oxygen therapy. The Current Tobacco Use section was marked No. Review of Resident #78's care plan dated 04/17/24 revealed a focused area for smoking and interventions included the Resident would not smoke with oxygen tank attached to wheelchair. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/26/24 at 9:15 AM an observation of residents in the designated smoking area, from the vending room exit door, revealed Resident #78 sitting in a wheelchair, smoking a lit cigarette and had a portable oxygen tank attached to the back of her wheelchair. Her nasal canula tubing was draped over the back of the wheelchair. There were 7 other residents smoking in the smoking area along with 5 staff. The 5 staff in the smoking area included the Maintenance Director, the Human Resources Coordinator, the Central Supply/Scheduler, and 2 contract housekeepers. This surveyor went to the Director of Nursing (DON) and asked her to observe the residents in the smoking area. There was no designated area for oxygen tank storage at the exit door. On 06/26/24 at 9:22 AM an observation was conducted of the designated smoking area with the DON. The DON stated, Oh no and went to the smoking area and removed the oxygen tank from the sleeve on the back on Resident #78's wheelchair. The DON stated the oxygen tank should have been removed from the wheelchair prior to exiting the building to go to smoke. The DON did not indicate why the oxygen tank should not be attached to the resident's wheelchair while she smoked. An interview was conducted with the Maintenance Director 06/26/24 at 10:15 AM and he stated he monitored the 2:00 PM smoke break. He stated one of the Nurse Aides (NA) usually escorted the residents to the smoking area. He stated all the residents were already outside when he got to the smoking area. He was unable to specifically recall the exact time he arrived in the smoking area. The Maintenance Director recalled he had opened the door for the residents to exit to the smoking area before he went to get the cigarette box containing the residents' smoking materials. He stated the Scheduler/Central Supply staff, Housekeeper #3, and the Human Resources Coordinator were already in the designated smoking area. He stated after opening the door for the residents to exit, he went to the nursing station to retrieve the residents' smoking materials. The Maintenance Director explained he took the cigarettes out to the smoking area. He said he lit all the residents' cigarettes because they were not allowed to keep smoking materials with them. He stated on 06/26/24 during the 9:00 AM smoke break, he lit Resident #78's cigarette. He said he did not notice the portable oxygen tank on the back of her wheelchair. He stated he had not received any education related to smoking and oxygen tanks. He further stated he knew oxygen was flammable and could explode. He said there were no signs warning against oxygen use in the smoking area. He stated, when the DON removed the oxygen tank from her wheelchair, Resident #78 told him the nurse had told her she could go to the smoking area with her portable oxygen tank if it was set on zero (0). The Maintenance Director stated the NAs usually removed the oxygen tanks prior to escorting the resident outside to smoke. He stated he did not know where the NAs stored the tanks when they removed them from the residents' wheelchairs. He stated he had no instructions in his office and no books containing instructions for storing portable oxygen. On 06/26/24 at 11:15 AM an observation and follow-up interview were conducted with the Maintenance Director. During the observation, measurements were obtained to show the proximity of the tank to the facility and to the resident for the risk of fire. The Maintenance Director measured from the vending room exit door to the location where Resident #78 was positioned in the designated smoking area. The measurements revealed Resident #78 was sitting 67 feet from the vending room exit door and 4 feet from other residents on each side of her wheelchair. There was a fire extinguisher with a full charge on one post and a fire blanket located in a metal box on another post. There were two Designated Smoking Area signs. There were no signs to warn against having oxygen in the designated smoking area. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted with Resident #78 on 06/26/24 at 11:45 AM and she stated her portable oxygen tank was off when she went to the designated smoking area at 9:00 AM. She stated she had been going outside with her portable oxygen tank attached to the back of her wheelchair for the last month. She stated she had been in the facility for three months and had started smoking regularly one month ago. She stated no one had ever told her she could not go outside with her portable oxygen tank attached to the back of her wheelchair until the DON removed her portable oxygen that morning (6/26/24). Resident #78 stated she transfers herself to her wheelchair and propels her wheelchair herself to the smoking area. The Resident stated prior to 06/26/24, Unit Manager #3 had gone out to the smoking area when Resident #78 had her portable oxygen tank on her wheelchair. She stated Unit Manager #3 told her it was okay to go outside to smoke with the portable oxygen tank on her chair as long as it was off. She stated she goes outside once in the morning and once in the evening. On 06/26/24 at 1:45 PM a follow up interview with Resident #78 was conducted and she stated she turned off her oxygen tank before she went to smoke. She stated she stopped at the nursing station on her way to the smoking area for the 9:00 AM smoke break, she got out of her wheelchair, turned off her oxygen, got back in the wheelchair and wheeled herself down the hall to the smoking area. She stated she did not recall if there was a nurse or other staff at the nursing station when she stopped there. On 06/26/24 at 3:35 PM during an observation Resident #78 demonstrated her ability to transfer from her bed to her wheelchair and from her wheelchair she stood and walked to the back of her wheelchair. She demonstrated she could turn her portable oxygen tank setting from 0 to 3 on the tank stationed in the portable tank holder on her wheelchair. Resident #78 stated she never removed or had staff remove her oxygen tank prior to going to the smoking area to smoke. She stated she always had her oxygen tank attached to her wheelchair when she went to smoke. On 06/26/24 at 12:15 PM an interview was conducted with NA #3 stated Resident #78 got up on her own every morning, transferred herself to her wheelchair, and transported herself to the smoking area. NA #3 stated Resident #78 was very independent and did not wait for staff to assist her with transfers or escort her to the smoking area. NA #3 stated she did not adjust the setting on Resident #78's portable oxygen tank. She stated Resident #78 adjusted the settings on her oxygen tank on her own. An interview was conducted on 06/26/24 at 12:20 pm with Unit Manager #3. She stated she had smoked with Resident #3 in the past. She stated she did not go to Resident #78's room and talk to her on the morning of 06/26/24. She stated Resident #78 had started going out to smoke 1 month ago after being in the facility for about 3 months. Unit Manager #3 stated she stocked the cigarette box and knew Resident #78 did not smoke much. Unit Manager #3 stated Resident #78 may have asked her to turn off her portable oxygen tank prior to going to smoke but she did not know Resident #78 was going to smoke. Unit Manager #3 stated she probably assumed Resident #78 was going back to her room. Unit Manager stated Resident #78's oxygen order was for continuous oxygen. Unit Manager #3 stated she was not sure where Resident #78 went after she turned the oxygen off. Unit Manager #3 stated she should not have turned off Resident #78's oxygen when she did not know where the Resident went after she turned the oxygen off. She stated Resident #78 could have gone to smoke or could have gone to her room; she did not know which. Unit Manager #3 stated that it was Resident #78's right to request the oxygen be turned off. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 06/26/24 at 12:55 PM an interview was conducted with Housekeeper #3. She stated at times she went to the designated smoking area to smoke while on her break while the residents were smoking. She stated she worked for a housekeeping agency and did not monitor residents. She stated she did not assist residents outside to the smoking area because it was not part of her job duties. She said she did not notice whether Resident #78 had a portable oxygen tank on her wheelchair that morning. She added she had not received training or education that pertained to smoking or oxygen tanks. An interview was conducted on 06/26/24 at 1:10 PM with the Central Supply/Scheduler and she stated she was in the smoking area 5 minutes prior to residents' arrival to the area. Central Supply/Scheduler stated from where she was positioned in the smoking area, she did not see the portable oxygen tank on back of Resident #78's wheelchair on 06/26/24. She stated she had never changed the setting on Resident #78's oxygen tank. She stated if asked, she would take a resident's oxygen tank to their room and put it in portable holder. She stated she received oxygen tank training during orientation and yearly through an online training program. She stated the training included the dangers of oxygen, flammables, and smoking. She added if she had noticed the oxygen tank on the back of Resident #78's wheelchair, she would have removed the tank from the smoking area due to the danger. On 06/26/24 at 1:25 PM an interview was conducted with Housekeeper #2. She stated she was not responsible for monitoring residents. She further stated she did not assist in escorting residents to the smoking area because it is 'not in her scope'. She said she had never paid attention to or noticed an oxygen tank on Resident #78's wheelchair. She stated that although she had not received training that pertained to smoking or oxygen use, she knew it could cause an explosion. An interview was conducted with the Human Resources Coordinator on 06/26/24 at 1:30PM and she stated she assisted with smoke breaks at times. She stated she assisted with monitoring the 9:00 AM smoke break on the morning of 06/26/24. The Human Resources Coordinator said she was already outside when the residents exited the building to smoking area. She stated she did not notice the oxygen tank on Resident #78's wheelchair. She stated she had never witnessed the Resident #78 with an oxygen tank on her wheelchair. She said if she had observed the oxygen tank on the back of the wheelchair, she would have removed the tank and she would have asked the Central Supply/Scheduler what to do with the tank. She stated she knew an oxygen tank was not supposed to go outside. On 06/26/24 at 2:30 PM a phone interview was conducted with the NC DHHS Life Safety Surveyor, and he stated that smoking and/or an open flame in the vicinity of a compressed oxygen cylinder is a fire hazard. He further stated it did not matter if the oxygen tank was off, it still posed a risk of fire and/or explosion. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on 06/26/24 at 5:15 PM with the Administrator and DON. The Administrator stated Resident #78's oxygen tank should not have been in the smoking area. She stated it was not the Maintenance Director's designated job duty to monitor the residents while they smoked. She stated the staff in the smoking area were responsible for monitoring the residents while they smoked. The DON stated she the daily assignment sheets included the NAs' names assigned to smoke breaks on each shift. The DON stated the Maintenance Director often offered to monitor the smoke breaks when the assigned NA was busy. The DON stated on weekends the assigned NA monitored the smoke breaks. She stated the smoke break assignment was subject to change to meet the facility needs. The Administrator stated the smoke break assignment falls under the Other duties as assigned description. The DON stated training related to smoking and oxygen use was provided for facility staff during orientation and yearly but was not provided to housekeeping, dietary, and therapy. The Administrator stated all staff were responsible for residents' safety while on the facility grounds. She stated that included break time if the staff were in the smoking area while residents were there smoking. She stated staff should have made sure Resident #78 did not enter the designated smoking area with her portable oxygen tank attached to her wheelchair because she was aware that oxygen was flammable and smoking near a tank whether it was turned on or off could potentially explode and harm residents. The Administrator was notified of immediate jeopardy on 06/26/24 at 6:36 PM. The facility provided the following credible allegation of immediate jeopardy removal. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as result of the noncompliance; and 1. The corrective action for alleged deficient practice was accomplished by: Prior to the incident, Resident # 78 was in her bed, utilizing the Oxygen concentrator in her room. Resident #78 self-transferred into her wheelchair with a portable oxygen tank that was turned off, on the back of her wheelchair. The resident attached the end of the tubing to the portable oxygen tank and placed the nasal canula tubing in the bag on the wheelchair. The oxygen was not turned on and the nasal canula was not applied. Resident self-propelled into smoking area while Maintenance Director held the door for her and other residents as they were entering the courtyard to smoke. The resident was observed smoking in the courtyard with a portable oxygen tank attached to her wheelchair by the surveyor. The surveyor observed the tank on the back of the wheelchair while the resident was in the courtyard smoking, the surveyor left the courtyard observation to notify the Director of Nursing (DON) who was in her office that she had a concern in the courtyard and asked her to walk to the courtyard. When the DON arrived at the door that enters the courtyard, the surveyor asked the DON if she saw anything wrong. The Director of Nursing immediately went to the courtyard and removed the oxygen tank from the back of resident #78's wheelchair on 06/26/2024. The surveyor observed 4 staff members, the Maintenance Director, the Human Resources Director and 2 housekeepers, in the designated smoking area while the resident was smoking with a portable oxygen tank on the back of her wheelchair. Immediately after the Director of Nursing removed the tank from the resident's wheelchair and placed the tank in the secured portable holder in residents #78's room, the Director of Nursing assessed the smoking area through observation for safety signage as it related to no smoking with oxygen and identified there was no signage regarding no oxygen in smoking area. The only sign posted was Designated Smoking Area. The Maintenance Director, Human Resources Director nor the 2 housekeepers were educated or trained on the importance of monitoring for the use of oxygen. None of the staff in the designated smoking area noticed the oxygen tank on the back of the wheelchair. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #78 was assessed for smoking on 4/11/24. The assessment identified the resident required supervision due to the inability to safely light a cigarette with a lighter. The maintenance director was assigned to supervise the smoke break at 9 am and failed to notice and remove the oxygen tank on the back of the wheelchair on resident #78 on 6/26/24. The Director of Nursing and Unit Manager identified residents with oxygen use through active physician orders on 06/26/2024. The list of these residents was provided to the social worker who educated the residents that oxygen / oxygen tanks are prohibited in or around the designated smoking area on 06/26/2024 and documented education provided in the residents' chart. The Director of Nursing and Unit Manager identified residents that smoke through smoking assessments on 06/26/2024 and this was verified against the list of current smokers. The list of residents was provided to the social worker who educated the identified residents on ensuring oxygen tanks were to be removed from the wheelchair before entering the smoking area on 06/26/2024 and documented education provided in the resident's chart. Specify the action the entity will take to alter the process or system failure to prevent serious adverse outcome from occurring or recurring, and when the action will be complete. The Director of Nursing educated the Maintenance Director on ensuring oxygen is removed from the wheelchair prior to entering smoking area and the dangers of smoking around oxygen, which is combustible and could cause a fire and/or burns on 06/26/2024. The Unit Manager placed an oxygen rack next to the exit to the courtyard, in the vending machine room, for the oxygen tanks to be placed in before exiting the building, on 06/26/2024. 100% of facility staff to include contract staff were educated by the Director of Nursing and Unit Manager on removing oxygen tanks and placing portable oxygen tanks in the secure oxygen rack prior to residents entering the courtyard smoking area on 06/26/2024. The Director of Nursing re-educated licensed nurses, certified nursing assistants, non-direct staff, contracted staff that includes therapy, housekeeping and dietary staff on the smoking policy, which includes oxygen is not permitted in the designated smoking area, and ensuring oxygen tanks are removed from the wheelchair and or ambulatory residents before entering the smoking area due to the dangers of smoking around oxygen on 06/26/2024. The Executive Director placed signs on the door entering the smoking area as a reminder to ensure oxygen tanks removed from the wheelchair and placed in oxygen rack before entering smoking area as well as signs that state NO OXYGEN OR OXYGEN TANKS BEYOND THIS POINT on 06/26/2024. The Executive Director placed NO OXYGEN / NO OXYGEN TANKS signs in the designated smoking area on 06/26/2024. The Director of Nursing and Unit Manager completed Skilled Check Off Competency for Smoking Safety in accordance with policies and procedures for oxygen safety precautions for oxygen use and not smoking around oxygen, for Licensed nurses, certified nursing assistants, department managers, receptionist, maintenance assistant and activity assistant; these are the staff members that are allowed to supervise smokers. These individuals listed have completed the skills check off competency includes smoking times, where to obtain smoking materials, oxygen tank removal, apron use, the location of fire blankets, fire extinguishers, and where to obtain the list of unsafe smokers on 06/26/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345089	A. Building B. Wing	07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Walnut Cove Health and Rehabilitation Center	511 Windmill Street Walnut Cove, NC 27052

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	The daily assignment sheets identify who is assigned to supervise the smokers and the daily assignment sheets are posted at both nurse's stations. If the assignments are changed, the nurse is responsible to communicate that to the newly assigned personnel. The skilled check off sheet that identifies the responsibilities for supervising the smokers is in notebooks placed in the vending machine room near the entrance to the designated smoking area and at each nurse's station. The responsibilities of the supervisor of the smokers are: o To know where smoke times are posted, at exit to courtyard o To obtain smoking materials from the South Hall Medication Cart o Assists residents to smoke area as needed o Removes any Oxygen tank and places in designated storage area in vending room (ask nurse for assistance in turning off oxygen as needed) o Prior to beginning smoke breaks, ensures that there is no oxygen or oxygen tanks anywhere in the courtyard o Utilizes smoking aprons from the designated smoking area located in the grey bin o Sanitize hands o Passes out cigarettes to each resident o Lights each resident's cigarette o Faces the residents smoking and continuously monitor their safety o Knows location of fire extinguisher o Knows location of fire blanket o Assists the residents back in the building after smoke break o Replaces any oxygen tanks from storage to the resident (ask nurse to turn on oxygen if needed) o Knows to return smoking materials to designated South Hall Medication Cart An ADHOC Quality Assurance Performance Improvement Committee was held on 06/26/2024 to formulate and approve a plan of correction for the deficient practice. Date of Immediate Jeopardy Removal 6/27/24. The title of the person responsible for implementing the acceptable credible allegation for immediate jeopardy removal. The Administrator is responsible for the credible allegation of immediate jeopardy removal. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Alleged date of IJ removal 06/27/24. A validation of immediate jeopardy removal was conducted on 06/27/24 as evidenced by the following verification of education for licensed nurses, certified nursing assistants, non-direct care staff, contracted staff that included therapy, housekeeping, and dietary staff on the smoking policy, which included oxygen is not permitted in the designated smoking area, and ensuring oxygen tanks are removed from the wheelchair and or ambulatory residents before entering the smoking area. Observation revealed a tank holder in the vending area next to the exit door leading to the smoking area. The exit door had a sign that read No Oxygen or Oxygen Tanks Beyond This Point and signs in the smoking area that read No Oxygen/No Oxygen Tanks. The IJ removal date of 6/27/24 was validated.