STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smithfield Manor Nursing and Rehab	902 Berkshire Road Smithfield, NC 27577

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49159 Based on record review and staff interviews, the facility failed to have a process that provided an opportunity to formulate an advance directive (Resident's #'s 292, 73, 287, 54) and have accurate advance directive documentation throughout the medical record (Resident #54) for 5 of 15 residents reviewed for advance directives. Findings included: 1a. Resident #292 was admitted to the facility on [DATE] with diagnoses including spinal cord disease and chronic obstructive pulmonary disease (a condition caused by damage to the airways or other parts of the lung). The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #292 was cognitively intact. Physician orders dated [DATE] included an order for cardiopulmonary resuscitation (CPR). There was no documentation in Resident #292's medical record that education regarding the formulation of advance directives and/or an opportunity to formulate an advance directive was offered. b. Resident #73 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #73 was cognitively intact. Physician orders dated [DATE] included an order for cardiopulmonary resuscitation (CPR). There was no documentation in Resident #73's medical record that education regarding the formulation of advance directives and/or an opportunity to formulate an advance directive was offered. c. Resident #287 was admitted to the facility on [DATE] with diagnoses including pyothorax (a condition where pus builds up around the lungs). (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The admission/5-day Minimum data Set (MDS) assessment dated [DATE] indicated Resident #287 was moderately cognitively impaired. Physician orders dated [DATE] included an order for cardiopulmonary resuscitation (CPR). There was no documentation in Resident #287's medical record that education regarding the formulation of advance directives and/or an opportunity to formulate an advance directive was offered. d. Resident #54 was admitted to the facility on [DATE] with diagnoses including chronic ischemic heart disease (heart weakening caused by reduced blood flow to the heart), type 2 diabetes mellitus (a chronic disease that occurs when the body doesn't produce enough insulin or doesn't use it properly), and generalized muscle weakness. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #54 was cognitively intact. Physician orders dated [DATE] for Resident #54 included an order for cardiopulmonary resuscitation (CPR). There was no documentation in Resident #54's medical record that education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered. An interview was conducted on [DATE] at 10:23 AM with the Admissions Coordinator. She stated she does not discuss advanced directives with residents. She further stated the Assessment/Admissions Nurse talks about code status/advanced directives with residents. An interview was conducted on [DATE] at 10:26 AM with the Assessment/Admission Nurse. She stated she reviews information regarding code status provided by the sending facility. She further stated if a resident is admitted to the facility from home, a verbal explanation of the difference between full code status and do not resuscitate (DNR) status is provided to the resident, however that discussion itself is not documented. An interview was conducted on [DATE] at 12:07 PM with the Director of Clinical Operations (former Director of Nursing). He stated code status was verified with the order from the hospital. There is no other written information that advance directives were discussed with residents. An interview was conducted on [DATE] at 2:54 PM with the Medical Director. She stated advance directives were discussed during the initial assessment, at least once per year, as well as with a resident's change in condition and/or recurrent hospitalization s. She further stated there was no specific statement that is documented regarding discussion of advance directives with the residents. An interview was conducted on [DATE] at 3:03 PM with the Administrator. She stated she assumed advance directives were discussed and documented with the residents by Admissions Coordinator. The Assessment/Admission Nurse should also be documenting the discussion of advanced directives; however, it was discovered that neither of these staff members were doing so. 49502 (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.Resident #25 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction, dementia, and cognitive communication deficit. Review of Resident #25's hard chart located at the nurse's station revealed a form dated [DATE] indicating the preference of Do Not Resuscitate (DNR) and was visually identified as a DNR. Resident #25's hard chart further revealed a physician's order dated [DATE] which indicated a DNR code status. Resident #25's care plan dated [DATE] revealed a focus for her code status with the intervention listed as if resident's heart stops beating, their wishes of being a full code status will be adhered to, and Cardiopulmonary Resuscitation (CPR) will be administered. Review of Resident #25's annual Minimum Data Set (MDS) dated [DATE] revealed Resident #5 was severely cognitively impaired. During an interview with the MDS Coordinator on [DATE] at 4:53 pm, she explained the MDS nurses were responsible for updating the care plans and they should the reflect the code status for Resident #25. Resident code status was discussed during the morning meetings with the different department heads. During an interview with MDS Nurse #1 on [DATE] at 4:10 pm, she indicated code status was discussed in morning meetings as well as care plan meetings. MDS Nurse #1 confirmed she was responsible for updating Resident #25's care plan and explained she was aware Resident #25's code status was DNR. The MDS Nurse #1 stated she entered the care plan intervention of full code status in error for Resident #25. In an interview with the Director of Nursing (DON) on [DATE] at 5:00 pm, she stated her expectations were the care plans reflect the accurate code status of the resident's wishes. Resident code status was discussed during the morning meetings as well as care plan meetings. The DON indicated the MDS nurses were responsible for updating the care plans.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on record review, observations and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of skin conditions (Resident #129), bowel and bladder (Resident #31), nutritional status (Resident #5) and discharge (Resident #134) for 4 of 36 residents whose MDS assessments were reviewed. Findings included: 1. Resident #129 was readmitted to the facility on [DATE] and diagnoses included the absence of right toes. The hospital discharge summary dated 12/30/2024 recorded on 12/26/2024 Resident #129 had a transmetatarsal amputation (surgery to remove part of the foot that included the metatarsals (bones between ankle and toes). The discharge summary further recorded Resident #129's surgical wound was being treated with a wound vacuum (type of treatment that uses a device to decrease air pressure of the wound to help it heal). Nursing documentation dated 12/30/2024 at 8:39 pm by the Admission Nurse reported Resident #129 was readmitted to the facility and had surgery to remove gangrenous toes from the right foot. Physician orders dated 12/30/2024 included an order to clean the right foot wound with Dakin's solution, apply black foam with wound vacuum at 125 millimeters of mercury continuous suction and change three times a week on Monday, Wednesday, Friday and as needed. Resident #129's January 2025 Treatment Administration Record recorded wound care to the right foot was administered as ordered from 1/1/2025 to 1/23/2025. The admission MDS assessment dated [DATE] indicated the resident was coded for no pressure ulcer, no venous or arterial ulcer and no surgical wound. The MDS further indicated Resident #129 was receiving no surgical wound treatments. An interview conducted with the MDS Coordinator on 1/23/2025 at 4:32 pm, after reviewing Resident #129's MDS dated [DATE] for skin conditions, she stated the MDS assessment was inaccurate because a surgical wound had not been coded for Resident #129. She stated the MDS data entered for Resident #129 was not reviewed prior to transmitting and her signature on the MDS only represented completion of data collection on the MDS assessment and not accuracy of the MDS. In a follow up interview on 1/24/2024 at 10:27 am with the MDS Coordinator, she stated Resident #129's MDS assessment dated [DATE] should have also been coded for receiving wound care. In an interview with the Administrator on 1/24/2025 at 10:28 am, she stated the MDS assessment for Resident #129 should be coded accurately. 2. Resident #31 was admitted to the facility on [DATE] with diagnoses including cancer. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing documentation dated 7/19/2024 reported Resident #31's urostomy bag was drained several times during the shift by the nurse. Resident #31's care plan last reviewed on 7/22/2024 included Resident #31 having an urostomy (a surgery that creates a stoma, a small opening in the abdomen used to remove body waste like urine, in the abdomen to collect urine outside of the body). Interventions included to empty the urostomy bag every shift and as needed, expel gas from urostomy bag as needed and notify physician of any changes in the appearance of the urostomy's stoma. Physician orders dated 10/21/2024 included an order to change urostomy bag as needed. There were no orders for an internal or external urinary catheter. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #31's assessment for bowel and bladder was coded for an indwelling urinary catheter, external urinary catheter, ostomy and incontinence in urine occasionally. On 1/21/2025 at 12:32 pm, Resident #31 was observed with a urostomy bag with amber urine on the left lower quadrant of the abdomen. In an interview with Nurse #5 on 1/23/2025 at 11:47 am, she stated Resident #31 had a urostomy due to bladder cancer and had never had an internal or external urinary catheter. In an interview with the MDS Coordinator on 1/24/2025 at 10:27am, she stated Resident #31's MDS assessment for bowel and bladder was inaccurately coded. She explained Resident #31 had a urostomy and stated Resident #31 should not have been coded for an internal or external urinary catheter. In an interview with the Administrator on 1/24/2025 at 10:28 am, she stated Resident #31's MDS assessment should have been coded accurately. 49502 3. Resident #5 was admitted to the facility on [DATE] with diagnoses which included coronary artery disease, hypertension, diabetes mellitus, and dementia. A physician's order dated 9/20/24 revealed an order for tube feeding four times a day. Review of Resident #5's quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #5 was severely cognitively impaired. The MDS dated [DATE] did not have Resident #5 coded as having a gastrostomy tube. During an interview with Nurse #1 on 1/23/25 at 1:55 p.m., she explained she had just finished giving Resident #5's tube feeding. During an interview with the MDS Coordinator on 1/23/25 at 4:47 p.m., she explained the dietary department coded the nutrition section of the MDS for all of the residents. She further explained that it was coded in error. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Food Service Director on 1/24/25 at 2:12 p.m. she explained she was responsible for coding the nutrition section of the MDS for Resident #5. She further explained it was an oversight and an error on her part. During an interview with the Director of Nursing (DON) on 1/23/25 at 5:00 p.m., she stated Resident #5's MDS should be accurately coded. During an interview with the Administrator on 1/24/25 at 3:15 pm she indicated the MDS should be completed accurately. 4. Resident #134 was admitted to the facility on [DATE] with diagnoses which included chronic kidney disease, hypertension, and atrial fibrillation. Review of Resident #134's discharge Minimum Data Set (MDS) dated [DATE] revealed he was cognitively impaired and was discharged to an acute hospital. Review of a progress note dated 12/4/24 noted Resident #134 had been discharged to an assisted living facility. During an interview with the MDS Coordinator on 1/23/25 at 4:37 p.m., she explained the MDS discharge for Resident #134 dated 11/28/24 was coded incorrectly and should have been coded as discharged to an assisted living facility. During an interview with the Director of Nursing (DON) on 1/23/25 at 5:00 p.m., she stated the resident's discharge MDS should accurately reflect their discharge status. During an interview with the Administrator on 1/24/25 at 3:15 p.m. she indicated the MDS should be completed accurately.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 Based on record review and staff interviews, the facility failed to develop and implement an individualized care person centered care plan in the area of nutrition for 3 of 36 residents reviewed for comprehensive care plans (Resident #67, Resident #122 and Resident #19). Findings included: 1 a. Resident #67 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus. A record of Resident #67's weights indicated on - 6/6/2024 Resident #67 weight was 144 pounds (lbs). - 8/7/2024 Resident #67 weight was 133 lbs. Physician orders included an order on 9/6/2024 for speech therapy evaluation for weight loss. Registered Dietician consult dated 9/9/2024 reported a weight loss of ten pounds in one month and recommended monitoring weights and adding sugar free shakes with all meals for nutritional support. A record of Resident #67's weights indicated on - 11/7/2024 Resident #67 weight was 134.6 lbs. - 12/4/2024 Resident #67 weight was 128.4 lbs. Physician orders included orders on 12/6/2024 for a carbohydrate controlled diet and sugar free shakes (meal replacement options for residents with diabetes) with all meals. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #67 was cognitively intact and required only assisting with setting up meal tray for eating. The MDS coded Resident #67's nutritional status with a weight of 128 pounds, on a therapeutic diet and with a weight loss more than 5% in the last month or 10% in more than six months and not on a physician prescribed weight loss regimen. Resident #67's care plan did not include a plan of care that addressed Resident #67's risk for a decrease in the nutritional status and/or weight loss. Resident #67's care plan was last reviewed on 12/10/2024. Dietary notes dated 12/11/2024 indicated Resident #67 was receiving supplemental sugar free protein and calorie dense shakes with meals due to weight loss and Resident #67's weight at 128.4 was a 5% weight loss over the past 30 days and 10% weight loss over the last 180 days. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Resident #122 was admitted to the facility on [DATE] with diagnoses including depression. Dietary notes dated 10/14/2024 indicated Resident #122 weighed 170.9 pounds with a an eleven pound weight loss in last 90 days. The report included Resident #122 was receiving a no added sugar protein and calorie dense frozen supplement with lunch and dinner meals for nutritional support and recommended monitoring Resident #122's weights and oral intake. Additional dietary notes on 11/25/2024 recorded Resident #122 weight as stable at 170.1 pounds. Nursing documentation dated 11/22/2024 reported a change in diet to pureed due to dysphagia. Speech therapy note dated 11/24/2024 indicated Resident #122 presented with oropharyngeal dysphagia and receiving a pureed and thin liquid diet. Resident #122's care plan did not include a plan of care that addressed Resident #67's risk for a decrease in the nutritional status and/or weight loss. Resident #67's care plan was last reviewed on 12/5/2024. Physician orders dated 12/6/2024 included an order for a fortified nutritional supplement shake for weight loss and malnutrition, 120 milliliters three times a day for weight loss and poor appetite. On 12/12/2024, Resident #122 diet was changed to a no added salt mechanical soft diet and thin liquids. The quarterly Minimal Data Set (MDS) assessment dated [DATE] indicated Resident #122 was cognitively intact and required assistance in setting up meal trays only for eating. The MDS coded Resident #122's nutritional status as receiving a therapeutic diet, weighing 170 pounds (lbs) with no weight loss. c. Resident #19 was admitted on [DATE] to the facility with diagnoses including diabetes mellitus, dementia and depression. Resident #19's weights indicated a weight loss in the last six months: - 7/8/2024 127.0 pounds (lbs). - 7/17/2024 124.0 lbs. - 7/24/2024 121.0 lbs. - 7/31/2024 119.0 lbs. - 8/7/2024 119.0 lbs. - 9/10/2024 114.0 lbs. - 9/11/2024 113.0 lbs. - 9/18/2024 113.0 lbs. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 9/25/2024 117.0 lbs. - 10/2/2024 112.0 lbs. -12/4/2024 107.9 lbs. -1/1/2025 103.2 lbs. Physician orders dated 7/8/2024 included an order for a regular diet and a protein and calorie dense frozen supplement for weight loss, with lunch and dinner. Dietary notes dated 9/9/2024 reported a 10% weight loss in 180 days. The note included the fortified nutritional supplement shake for weight loss and malnutrition was increased from 30 milliliters to 60 milliliters three times a day and continued to monitor weights. Physician notes dated 9/16/2024 reported a six pounds (5%) weight loss in one month and the weight loss team addressed with the addition of the fortified nutritional supplement shake three times a day for nutritional support. The annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #19 was severely cognitively impaired and coded Resident #19's nutritional status receiving a therapeutic diet. A weight of 112 pounds and with weight loss more than 5% in the last month or 10% in more than six months and not on a physician prescribed weight loss regimen. The annual MDS triggered a concern for nutritional status for Resident #19's care plan. Resident #19's care plan did not include a plan of care that addressed Resident # 67's risk for a decrease in the nutritional status and/or weight loss. Resident #67's care plan was last reviewed on 12/3/2024. In an interview on 1/24/2025 at 3:18 pm with the MDS Coordinator, she stated the Dietary Manager was responsible for creating a care plan for residents who were at risk for a decrease in their nutritional status. She explained meetings were held to discuss residents with weight loss and the Dietary Manager was responsible for updating the residents' care plan after weight loss meetings. In an interview on 1/24/2025 at 3:26 pm with the Dietary Manager, she stated she was responsible for entering the initial care plans for residents when there was a risk for a change in their nutritional status and updating residents' care plans for weight loss discussed in the monthly weight loss meeting. She explained she been trained on the new electronic medical record system in July 2024 and had access to the information to create care plans for Resident #67, Resident #122 and Resident #19 and had not entered or updated the care plans for the residents. She stated she knew she was responsible for entering the nutrition information into the care plans and had not been able to complete the tasks and was working on entering the information into the care plans. In an interview with the Administrator on 1/24/2025 at 3:48 pm, she stated she was unaware that Resident #67, Resident #122 and Resident #19 care plans did not include a nutritional risk care plan. She stated the Dietary Manager should have been updating the residents' care plan due to weight loss and included interventions.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49502 Based on observation, record review, and Medical Director, Pharmacist Consultant, Sales Representative and staff interviews, the facility failed to protect the resident from a potential flammable hazard for 1 of 3 residents reviewed for accidents. (Resident #16) The findings included: The National Institute of Health's website included an article dated October 2016 titled Safety in the use of [name brand of petroleum jelly] during oxygen therapy: the pharmacist's perspective indicated the following: The justification of the combination of [name brand of petroleum jelly] and oxygen has been subject for discussion in many hospitals. Due to the lack of evidence-based data in literature, we have provided recommendations from a pharmacist's perspective. The use of petroleum-based products should be avoided when handling patients under oxygen therapy. Whenever a skin moisturizer is needed for lubrication or rehydration of dry nasal passages, the lips or nose when breathing oxygen, consider the use of oil-in water creams or water-based products. Resident #16 was readmitted to the facility on [DATE] with diagnoses which included hypoxia (a condition that occurs when the body or a part of the body doesn't receive enough oxygen), and cognitive communication deficit. A physician's order dated 12/23/24 revealed an order for oxygen at 1 liter per minute (LPM) via nasal cannula (NC) to maintain oxygen saturation rates greater than 94% every shift for hypoxia. A physician's order written by the Medical Director dated 12/24/24 revealed an order for white petroleum jelly to be applied to Resident #16's lips every day and every evening for dry lips. Review of Resident #16's annual Minimum Data Set (MDS) dated [DATE] revealed Resident #16 to be severely cognitively impaired. Resident #16 was dependent on staff for all activities of daily living (ADL) and transfers. Resident #16 was coded for continuous oxygen therapy. Resident #16's January 2025 Treatment Administration Record (TAR) revealed the white petroleum jelly had been initialed as administered every day twice a day. An observation made on 1/21/25 at 1:05 pm revealed Resident #16 laying in bed with the NC in her nares (the openings of the nose, or nostrils). Resident #16's lips were not visually dry. A phone interview was conducted on 1/24/25 at 12:56 pm with the Sales Representative from an oxygen concentrator repair company. The Sales Representative explained the petroleum jelly was safe to use with residents who received oxygen therapy. When asked about the petroleum jelly being inflammable, the Sales Representative stated the petroleum jelly was heavily processed and the risk would be small. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Nurse #2 on 1/24/25 at 9:58 am, she indicated she was applying petroleum jelly but was unaware of the potential hazard of petroleum jelly when used on residents with oxygen. Nurse #2 further indicated if the white petroleum jelly was flammable then it should not be used. Nurse #2 was assigned the day shift (7:00 am until 3:00 pm) for Resident #16 and was familiar with Resident #16. In an interview with the Director of Nursing (DON) on 1/24/25 at 3:15 pm, she stated the facility should not be using petroleum jelly on residents who received oxygen therapy. The risk was small, but the petroleum jelly should not be used. During a phone interview with the Pharmacist Consultant on 1/24/25 at 8:52 am, she indicated petroleum jelly was not good to use with residents on oxygen therapy because it was considered flammable. She further indicated the risk was small; however, she would not want to take the chance of using petroleum jelly. In a phone interview with the Medical Director on 1/24/25 at 2:45 pm, she stated petroleum was flammable and there was a small risk for an adverse reaction for residents who were receiving both oxygen therapy and petroleum jelly. She further stated she was unaware of the petroleum jelly being used for Resident #16 and when it was brought to her attention, changes were made for Resident #16.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49502 Based on observations, record review, interviews with the Medical Director and staff, the facility failed to provide supplemental oxygen as ordered by the physician for 1 of 1 resident reviewed for respiratory care (Resident #16). The findings included: Resident #16 was readmitted to the facility on [DATE] with diagnoses which included hypoxia, (a condition that occurs when the body or a part of the body doesn't receive enough oxygen). Resident #16's care plan dated 12/23/24 revealed a focus for oxygen therapy at 1 liter (L) via nasal cannula (NC) for hypoxia. Intervention included oxygen saturations to be monitored as ordered and as needed. A physician's order dated 12/23/24 revealed an order for oxygen at 1 L via NC to maintain oxygen saturation rates greater than 94% every shift for hypoxia. Review of Resident #16's annual Minimum Data Set (MDS) dated [DATE] revealed Resident #16 was severely cognitively impaired. Resident #16 was dependent on staff for all activities of daily living (ADL's) and transfers. Resident #16 was coded for continuous oxygen therapy. An observation made on 1/21/25 at 1:05 pm revealed Resident #16 laying in bed with the NC in her nares (the openings of the nose, or nostrils). An observation of the in-room oxygen concentrator revealed the oxygen setting at 2 L. Resident #16 had no signs or symptoms of respiratory distress. A follow up observation was made on 1/21/25 at 2:56 pm which revealed Resident #16's in-room oxygen concentrator setting remained at 2 L. Resident #16 had no signs or symptoms of respiratory distress. Resident #16 was observed at lunch on 1/23/25 at 12:15 pm which revealed Resident #16's in-room oxygen concentrator setting remained at 2 L. No signs or symptoms of distress were observed. During an interview at the medication cart on 1/23/25 at 5:11 pm with Nurse #1, she stated Resident #16's order was for 1L of oxygen via NC. Nurse #1 verified the physician order in the electronic medication administration record (eMAR) which revealed Resident #16 was ordered continuous oxygen at 1 L via NC. An observation with Nurse #1 was completed on 1/23/25 at 5:13 pm in Resident #16's room. Nurse #1 observed the in-room oxygen concentrator setting at 2 L. Nurse #1 alerted her supervisor and asked him if she needed to change the oxygen setting to 1 L. Nurse #1 indicated nurses should be checking the in-room oxygen concentrators every shift to make sure the correct ordered liter was still in place for their residents on supplemental oxygen. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. Building B. Wing	01/24/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Quality Coordinator (QA) on 1/23/25 at 5:15 pm, he explained the knob could have been accidentally bumped when performing care. He stated he did not know why the oxygen setting was at 2 L, but it should have been on 1 L as ordered by the physician. Nurses should be checking the in-room oxygen concentrators every shift to make sure the correct ordered liter was still in place for their residents on supplemental oxygen. An interview with the Director of Nursing (DON) on 1/23/25 at 5:17 pm, she stated nurses should be checking supplemental oxygen settings daily to ensure residents were on the correct ordered liter. An interview with the Medical Director was completed on 1/24/25 at 2:45 pm. The Medical Director explained Resident #16's in-room oxygen concentrator should have been set at the correct ordered liter. She further explained there was no harm to Resident #16 for being on 2 L instead of 1 L of oxygen.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345175	A. Building B. Wing	01/24/2025

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41387 Based on observations and staff interviews, the facility failed to secure residents' medications in a locked medication cart for 1 of 6 medication carts observed (200-hall upper west medication cart). Findings included: On 1/24/2025 at 6:14 am, the 200-hall upper west medication cart was observed unlocked and located outside the nurse's station in the hallway approximately 15 feet from an unlocked entrance to the facility where staff were observed exiting as the surveyor entered the facility. There were no staff observed at the 200-hall upper west medication cart or in the nursing station. There were also no residents and/or staff observed on the 200-hall upper west. On 1/24/2025 at 6:15 am, Nurse #3 was observed exiting a resident's room that was located 30 feet away from the 200-hall upper west medication cart into the 200-hall and walking toward the unlocked 200-hall upper west medication cart. On 1/24/2025 at 6:16 am during an interview with Nurse #3, Nurse #3 was observed locking the 200-hall upper west medication cart. She stated she was in a resident's room administering medications and explained the 200-hall upper west medication cart was to be locked before leaving the medication cart unattended. When asked why the 200-hall upper west medication cart was observed unattended and unlocked upon entering the facility, Nurse #3 did not provide a reason. In an interview with the Director of Nursing on 1/24/2025 at 4:02 pm, she stated the 200-hall upper west medication cart was to be locked at all times when Nurse #3 was not present at the medication cart.