

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER Pruithhealth-Crystal Coast		STREET ADDRESS, CITY, STATE, ZIP CODE 2416 US Highway 70 East Beaufort, NC 28516	
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)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident, staff, and Medical Doctor interviews, the facility failed to administer oxygen at the physician prescribed rate for 1 of 1 resident reviewed for respiratory care (Resident #48). The findings included: Resident #48 was admitted to the facility on [DATE] with diagnoses which included chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease with acute exacerbation, chronic diastolic (congestive) heart failure, acquired absence of lung (part of), and dependence on supplemental oxygen. A review of Resident #48's physician's orders, Oxygen at 3 LPM [liters per minute] via nasal cannula (tubing that delivers oxygen from an oxygen source to the resident's nose) and was written on 1/8/26. A review of Resident #48's care plan, initiated on 1/9/26, revealed a problem of at risk for shortness of breath and respiratory distress due to chronic respiratory failure with hypoxia [a deficiency in the amount of oxygen reaching the body tissues, cells or organs, preventing them from maintaining normal healthy function], requiring continuous O2 [oxygen] use via nasal cannula. Interventions included oxygen as ordered. A review of Resident #48's admission Minimum Data Set (MDS), dated [DATE], revealed Resident #48 to be cognitively intact and on oxygen therapy. An observation and interview with Resident #48 was conducted on 1/20/26 at 12:27 PM. She was observed sitting on the side of her bed with her overbed table in front of her and was receiving oxygen therapy via nasal cannula. The oxygen concentrator was placed next to her nightstand and was set to deliver oxygen at 2 LPM. Resident #48 stated she thought the reason she was on oxygen was because she had lung cancer years ago. She did not know what the oxygen flow rate on the concentrator was supposed to be set at. A telephone interview was conducted with Nurse #2 on 1/21/26 at 3:39 PM. Nurse #2 confirmed she had been Resident #48's nurse on 1/20/26 from 7:00 AM to 7:00 PM. Nurse #2 stated she knew that Resident #48's oxygen orders were for 3 LPM. When asked if she recalled checking the resident's oxygen concentrator on 1/20/26, she stated she had so much going on that day that she might not have checked the settings on the oxygen concentrator. Nurse #2 said that Resident #48's O2 sats (oxygen saturation) were usually always within normal limits. A second observation of Resident #48 was made on 1/21/26 at 8:51 AM. She was lying in her bed and was observed receiving oxygen therapy via nasal cannula. The oxygen concentrator was placed next to her nightstand and was set to deliver oxygen at 2 LPM. An interview was conducted with Nurse #1 on 1/21/26 at 8:53 AM. Nurse #1 stated she was Resident #48's nurse on that date, from 7:00 AM to 7:00 PM. She explained that nurses were supposed to check the settings on an oxygen concentrator against the physician's orders once a shift. She admitted she had not done that when she went into Resident #48's room around 8:30 AM to 9:00 AM. Nurse #1 explained this was the first time she had worked on the hall where Resident #48 resided and did not know the residents well yet. She checked Resident #48's physician orders for oxygen and stated the concentrator should be set to deliver at 3 LPM. A third observation of Resident #48's oxygen concentrator's settings was made on 1/21/26 at 8:58 PM with Nurse #1. Nurse #1 confirmed the oxygen concentrator was set to</p> <p>(continued on next page)</p>		

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>deliver oxygen at 2 LPM. Nurse #1 then increased the oxygen concentrator's settings to deliver oxygen at 3 LPM. Nurse #1 stated she would continue to monitor the Resident. A telephone interview was conducted with the facility's Medical Doctor (MD) on 1/22/26 at 4:17 PM. The MD stated Nurse #1 had informed him of Resident #48's oxygen concentrator set to deliver oxygen at a rate of 2 LPM, instead of 3 LPM. The MD stated that no harm came to Resident #48 and explained that the difference between 3 LPM and 2 LPM was so minimal that it really would not have made a difference in the Resident's oxygen saturations. An interview was conducted with the Director of Nursing (DON) on 1/21/26 at 2:00 PM. The DON explained after Nurse #1 informed her that Resident #48's oxygen concentrator had been set to deliver 2 LPM instead of 3 LPM, she instructed the nurse to call and inform the MD, and that she would call the family to inform them. The DON further explained that the family member she called was also a nurse at the facility and when they spoke, she had asked him if Resident #48 would ever mess with the settings on an oxygen concentrator. She said the family member informed her that Resident #48 would occasionally do that when she was at home. The DON did not know how the settings on Resident #48's concentrator got changed. The DON stated it was her expectation that nursing staff check the settings on the oxygen concentrator against the doctor's orders every shift. An interview was conducted with the Administrator on 1/21/26 at 2:04 PM. She stated it was her expectation that nursing staff follow the MD orders and facility policy regarding oxygen therapy.</p>		