

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345410	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2024
NAME OF PROVIDER OR SUPPLIER Central Continuing Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1287 Newsome Street Mount Airy, NC 27030	

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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50045</p> <p>Based on record review and staff interviews, the facility failed to develop a baseline care plan that addressed a resident's weight-bearing status and the use of a sling to the right upper extremity for 1 of 1 resident (Resident #47) reviewed for baseline care plan.</p> <p>The findings included:</p> <p>Resident #47 was admitted to the facility on [DATE] with a diagnosis of a right distal clavicle (collarbone) fracture (break).</p> <p>A review of a baseline care plan dated 7/30/2024 revealed Resident #47 had a fracture and staff were to follow rehabilitation orders and/or recommendations.</p> <p>A review of a physician's order dated 7/30/2024 revealed Resident #47 was to always wear sling on his right upper extremity and was non-weightbearing to his right upper extremity.</p> <p>An interview was conducted on 8/6/2024 at 10:05 am with the Care Plan Nurse. The Care Plan Nurse stated a baseline care plan was completed when a resident was admitted to the facility. The Care Plan Nurse stated it was the responsibility of the hall nurse who admitted the resident to complete the baseline care plan. The Care Plan Nurse stated Resident #47 was ordered to always wear a sling to his right upper extremity and was non-weightbearing to his right upper extremity. The Care Plan Nurse verified the sling and weight-bearing status were not on his baseline care plan and should have been. The Care Plan Nurse stated she was not sure why the sling and weight-bearing status were not included because she was not the person who completed the baseline care plan.</p> <p>An interview was conducted on 8/6/2024 at 11:11 am with Nurse #2. Nurse #2 stated she admitted residents to the facility and completed the admission for Resident #47. Nurse #2 stated Resident #47 was wearing a sling to his right upper extremity when he was admitted to the facility. Nurse #2 stated she knew that he was non-weightbearing to his right upper extremity. Nurse #2 verified the baseline care plan did not include the application of a sling to the right upper extremity and the non-weightbearing status of the right upper extremity. Nurse #2 stated the sling and weight-bearing status should have been included in the baseline care plan but she must have forgotten to write that information in.</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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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on 8/7/2024 at 8:24 am with the Director of Nursing (DON). The DON stated the baseline care plan was completed by the hall nurse when a resident was admitted to the facility. The DON stated the baseline care plan should include information/instructions specific to the resident and their needs. The DON stated she was unaware the sling and weight-bearing status had not been documented on the baseline care plan and it should have been.</p> <p>An interview was conducted on 8/7/2024 at 8:31 am with the Administrator. The Administrator was not aware the sling and weight-bearing status for Resident #47 had not been documented on the baseline care plan and stated it should have been.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50045</p> <p>Based on observations, record review, and staff interviews the facility failed to provide fingernail care for a dependent resident for 1 of 4 residents reviewed for activities of daily living (ADL) (Resident #35).</p> <p>The findings included:</p> <p>Resident #35 was admitted to the facility on [DATE] with diagnosis' which included hemiplegia (inability to move one side of the body).</p> <p>A review of a care plan dated 5/13/2024 revealed Resident #35 had impaired mobility related to left-sided hemiplegia with interventions which included for staff to encourage Resident #35 to participate in activities of daily living (ADL) care as able and to assist him as needed.</p> <p>A review of a quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #35 was cognitively intact and was not coded for rejection of care. Resident #35 was coded for impairment on one side of his upper extremities and required moderate assistance with personal hygiene.</p> <p>A review of the Electronic Health Record shower documentation dated 8/3/2024 revealed Resident #35 received a shower from Nurse Aide (NA) #1.</p> <p>An observation was conducted on 8/4/2024 at 9:55 am. Resident #35 was observed to have half-inch long fingernails over the tip of the finger with a brown substance noted under all ten fingernails on both hands.</p> <p>An observation was conducted on 8/5/2024 at 8:18 am. Resident #35 was observed to have half-inch long fingernails over the tip of the finger with a brown substance noted under all ten fingernails on both hands.</p> <p>An interview was conducted on 8/5/2024 at 3:11 pm with Resident #35. Resident #35 stated his fingernails had gotten long and he had asked staff to cut his fingernails but was unable to recall when he asked or who he had asked. Resident #35 stated his fingernails look awful and had been snagging his bedding.</p> <p>An interview was conducted on 8/5/2024 at 3:15 pm with NA #2. NA #2 stated she was assigned Resident #35 and worked second shift (3:00 pm to 11:00 pm). NA #2 stated she was not sure who was responsible for cleaning and cutting fingernails and stated any NA could clean underneath fingernails. NA #2 observed Resident #35's fingernails and agreed that they were long, dirty, and need to be cleaned and cut. NA #2 stated she had not noticed his fingernails and had not offered to cut or clean his fingernails.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on 8/6/2024 at 9:54 am with NA #4. NA #4 stated she worked first shift (7:00 am to 3:00 pm) and was on the shower team. NA #4 stated the shower team was primarily responsible for cleaning and cutting nails. NA #4 stated Resident #35 was scheduled to receive showers on Tuesdays, Thursdays, and Saturdays. NA #4 stated she had given Resident #35 a shower last week and he had refused to have his nails cut, but she reported she cleaned his nails when she gave him a shower.</p> <p>An interview was conducted on 8/6/2024 at 9:01 am with the Charge Nurse. The Charge Nurse stated the shower team was responsible for providing nail care. The Charge Nurse stated that Resident #35 would occasionally refuse to have his fingernails cut. The Charge Nurse was not aware that Resident #35's fingernails were long and dirty.</p> <p>An interview was conducted on 8/6/2024 at 1:48 pm with NA #1. NA #1 stated she worked on second shift (3:00 pm to 11:00 pm) and was assigned Resident #35. NA #1 stated she had not given Resident #35 a shower or performed nail care that day and stated she had documented she had given Resident #35 a shower to get the task to go away. NA #1 stated the shower team was responsible for completing nail care and stated she had not noticed Resident #35's fingernails and reported he had not asked her to cut and clean his fingernails.</p> <p>A follow-up interview was conducted on 8/6/2024 at 10:01 am with the Charge Nurse. The Charge Nurse stated she went and performed fingernail care for Resident #35 and that he had agreed to have his fingernails cut, cleaned, and filed.</p> <p>An interview was conducted on 8/7/2024 at 8:17 am with the Director of Nursing (DON). The DON stated nail care was performed by the shower team on the resident's shower days. The DON stated NAs and Nurses on the hall could perform nail care, but nail care was primarily completed by the shower team. The DON stated she was not aware Resident #35 had long, dirty nails.</p> <p>An interview was conducted on 8/7/2024 at 8:28 am with the Administrator. The Administrator stated he was not aware Resident #35 had long, dirty fingernails but knew that he did not like to have his fingernails cut.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>37280</p> <p>Based on observations, record review and interviews the facility failed to secure an indwelling urinary catheter tubing to prevent tension or trauma for 1 of 3 residents reviewed for urinary catheter (Resident #86).</p> <p>The finding included:</p> <p>Resident #86 was admitted to on 08/02/24 to the facility with diagnoses that included urinary retention.</p> <p>The baseline care plan dated 08/02/24 revealed Resident #86 was alert and oriented to person and to check catheter strap every shift.</p> <p>The admission Minimum Data Set assessment was not yet completed as of 08/07/24.</p> <p>A review of Resident #86's physician orders dated 08/02/24 revealed an order for a urinary catheter to straight drainage due to the diagnosis of urinary retention. There was also an order to check placement of a catheter strap every shift.</p> <p>On 08/04/24 at 9:49 AM an observation was made of Resident #86 lying in bed with an indwelling urinary catheter attached to the left side of the bed frame. When asked the Resident uncovered her left thigh to show there was no stabilizing device present on the catheter tubing to prevent tension or trauma.</p> <p>A review of Resident #86's Treatment Administration Record (TAR) for 08/2024 revealed the catheter strap placement check was initialed off as completed at 2:30 PM on 08/04/24 by Nurse #1.</p> <p>On 08/05/24 at 2:54 PM an observation was made of Resident #86 being toileted by Nurse #4 and Nurse Aide (NA) #5. It was noted that the Resident did not have a stabilizing device in place on the catheter tubing to prevent tension or trauma.</p> <p>An interview was conducted with Nurse #4 and NA #5 on 08/05/24 at 2:54 PM. The staff explained that they both got Resident #86 up out of bed and dressed earlier that morning and did not notice that the Resident did not have a stabilizing device in place for the catheter tubing. Nurse #4 stated it was protocol that they used stabilizing devices on all residents with urinary catheters.</p> <p>During an interview with Nurse #1 on 08/06/24 at 1:58 PM the Nurse confirmed that she initialed the TAR on 08/04/24 to indicate that Resident #86 had a stabilizing device in place. The Nurse explained that when she checked the Resident she was up in her wheelchair and could not positively determine the device was in place but thought it was, so she initialed the TAR to indicate she checked it. Nurse #1 stated she should not have initialed the TAR unless she was sure the device was in place.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Director of Nursing (DON) on 08/07/24 at 8:59 AM the DON explained that it was policy that residents who have an indwelling urinary catheter have a stabilizing device in place to prevent tension and trauma.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 50045</p> <p>Based on observations, record review, and staff interviews the facility failed to post cautionary safety signs that indicated the use of oxygen for 5 of 7 residents reviewed for oxygen use (Resident #47, #30, #48, #19, and #70).</p> <p>The findings included:</p> <p>a. Resident #47 was admitted to the facility on [DATE] with a diagnosis of respiratory failure.</p> <p>A physician's order dated 7/30/2024 revealed Resident #47 was ordered to wear 2 liters per minute of oxygen continuously.</p> <p>An observation was conducted on 8/4/2024 at 9:56 am. Resident #47 was observed with his eyes closed in bed and oxygen being administered at a rate of 2 liters per minute via nasal cannula. There was no oxygen signage outside of Resident #47's room or on the doorframe.</p> <p>An interview was conducted on 8/5/2024 at 3:34 pm with Medication Aide (MA) #1. MA #1 stated when a resident was ordered oxygen, there was an order on the Medication Administration Record (MAR). MA #1 stated the nurses let the Nurse Assistants (NAs) know if a resident was ordered oxygen. MA #1 stated the facility staff used to have an indication outside of the room that oxygen was in use but stopped due to the signage being a violation of the resident's privacy.</p> <p>An observation was conducted on 8/5/2024 at 5:00 pm. Resident #47 was observed with his eyes closed in bed and oxygen being administered at a rate of 2 liters per minute via nasal cannula. There was no oxygen signage outside of Resident #47's room or on the doorframe.</p> <p>An observation was conducted on 8/6/2024 at 8:09 am. Resident #47 was observed awake in bed and oxygen was being administered at a rate of 2 liters per minute via nasal cannula. There was no oxygen signage outside of Resident #47's room or on the doorframe.</p> <p>An interview was conducted on 8/6/2024 at 9:04 am with the Charge Nurse. The Charge Nurse stated if a resident was supposed to wear oxygen there was an order in the chart from the physician. The Charge Nurse stated she was unsure if the facility still used oxygen signage outside of resident rooms to indicate that oxygen was in use.</p> <p>An interview was conducted on 8/7/2024 at 8:22 am with the Director of Nursing (DON). The DON stated if a resident was on oxygen, oxygen usage was displayed on the resident's vital signs in the Electronic Health Record (EHR). The DON stated the facility did not use oxygen signage outside of resident rooms because they had been told that was a violation of the resident's privacy.</p> <p>An interview was conducted on 8/7/2024 at 8:33 am with the Administrator. The Administrator stated that in the past, the facility would place a magnet outside of the resident's room if oxygen was in use but had stopped because they were told that was a privacy/dignity issue.</p> <p>35789</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>b. Resident #70 was readmitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease and shortness of breath.</p> <p>Review of physician order dated 09/06/23 read: oxygen at 3 liters via nasal cannula continuously.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed that Resident #70 was cognitively intact and required the use of oxygen.</p> <p>An observation of Resident #70 was made on 08/04/24 at 1:04 PM. Resident #70 was resting in bed and was noted to have oxygen in use at 3 liters per minute via nasal cannula. There was no cautionary signs noted on the door frame or in Resident #70's environment where the oxygen was being delivered.</p> <p>An observation of Resident #70 was made on 08/05/24 at 10:33 AM. Resident #70 was resting in bed and was noted to have oxygen in use at 3 liters per minute via nasal cannula. There was no cautionary signs noted on the door frame or in Resident #70's environment where the oxygen was being delivered.</p> <p>An interview was conducted on 8/6/2024 at 9:04 am with the Charge Nurse. The Charge Nurse stated if a resident was supposed to wear oxygen there was an order in the chart from the physician. The Charge Nurse stated she was unsure if the facility still used oxygen signage outside of resident rooms to indicate that oxygen was in use.</p> <p>An observation of Resident #70 was made on 08/06/24 at 11:24 AM. Resident #70 was resting in bed and was noted to have oxygen in use at 3 liters per minute via nasal cannula. There was no cautionary signs noted on the door frame or in Resident #70's environment where the oxygen was being delivered.</p> <p>Nurse Aide (NA) #6 was interviewed on 08/06/24 at 2:22 PM. She stated that Resident #70 wore his oxygen all the time when in his room and if he was out of his room, they obtained him a portable oxygen tank to use. NA #6 stated she was not sure if the facility used oxygen signs or no smoking signs, but she did not think there was any signs on Resident #70 door or in his room that indicated no smoking or that oxygen was in use.</p> <p>Nurse #5 was interviewed on 08/06/24 at 4:24 PM. Nurse #5 stated that she was not sure about any cautionary signs within the facility, but she thought the front door of the facility stated, no smoking. She stated she would have to find out if the facility used cautionary signs on the doors or in resident rooms where oxygen was being used.</p> <p>An interview was conducted on 8/7/2024 at 8:22 am with the Director of Nursing (DON). The DON stated if a resident was on oxygen, oxygen usage was displayed on the resident's vital signs in the Electronic Health Record (EHR). The DON stated the facility did not use oxygen signage outside of resident rooms because they had been told that was a violation of the resident's privacy.</p> <p>An interview was conducted on 8/7/2024 at 8:33 am with the Administrator. The Administrator stated that in the past, the facility would place a magnet outside of the resident's room if oxygen was in use but had stopped because they were told that was a privacy/dignity issue.</p> <p>37280</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>c. Resident #19 was admitted to the facility on [DATE] and had diagnoses that included respiratory failure and hypercapnia (abnormal carbon dioxide levels in the blood).</p> <p>Review of Resident #19's Minimum Data Set, dated dated dated [DATE] revealed his cognition was severely impaired and he wore oxygen.</p> <p>A review of Resident #19's physician orders dated 03/22/24 revealed an order for continuous oxygen at 2 liters per minute via nasal cannula.</p> <p>An observation made on 08/04/24 at 10:19 AM revealed Resident #19 was wearing oxygen via nasal cannula, and it was being delivered by an oxygen concentrator. There was no oxygen cautionary sign posted near the Resident's room to indicate that oxygen was in use.</p> <p>Subsequent observations made on 08/05/24 at 11:06 AM and 2:49 PM and on 08/06/24 at 8:30 AM and 9:07 AM revealed Resident #19 wore continuous oxygen via nasal cannula and there were no oxygen cautionary signs posted near the Resident's room.</p> <p>On 08/06/24 at 10:40AM during an interview with the Charge Nurse, she stated that they did not post oxygen signs on the residents' doors anymore because it was a dignity issue.</p> <p>During an interview with the Director of Nursing (DON) on 08/07/24 at 8:22 AM she explained the facility did not utilize the cautionary oxygen signs throughout the facility because the facility was smoke free which included vapes (electronic cigarettes) and were not allowed in the facility. The DON indicated the oxygen cautionary signs were a violation of the residents' privacy.</p> <p>An interview was conducted on 8/7/2024 at 8:33 AM with the Administrator. The Administrator stated the facility was smoke free. The Administrator stated that in the past, the facility would place a magnet outside of the resident's room if oxygen was in use but had stopped because they were told that was a privacy/dignity issue.</p> <p>38515</p> <p>d. Resident #30 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD), and chronic respiratory failure.</p> <p>Review of Resident #30's most recent quarterly Minimum Data Set assessment dated [DATE] revealed she was cognitively intact. She was coded with having shortness of breath or trouble breathing while lying flat and was coded as utilizing oxygen therapy while admitted to the facility.</p> <p>A review of Resident #30's care plan revealed a care plan area for [Resident #30] has the diagnoses of COPD a d respiratory failure and requires oxygen therapy. Interventions included to administer her oxygen as ordered and ensure that Resident #30's oxygen supply was available as needed.</p> <p>Review of Resident #30's physician orders revealed the following orders:</p> <p>- Check oxygen saturation every shift and record results - may increase oxygen as needed to maintain oxygen saturation at greater than 92%.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Continuous oxygen at 2 liters per minute via a nasal cannula.</p> <p>An observation of Resident #30 completed on 08/04/24 at 10:22 AM revealed resident to be in her wheelchair in her room. Resident was observed with her nasal cannula on her face and was receiving oxygen from her room concentrator at 2 liters per minute. An observation of Resident #30's room and doorway revealed no documented signage indicating the use of oxygen in the room.</p> <p>An additional observation of Resident #30's room and doorway completed on 08/05/24 at 2:55 PM continued to revealed no documented signage that indicated oxygen was in use in the room.</p> <p>An interview with Nurse Aide #6 on 08/05/24 at 3:15 PM revealed she was aware the Resident #30 wore oxygen. She further reported she was unsure if the facility utilized oxygen in use signs and verified that there was not one in Resident #30's room or on her doorway.</p> <p>An interview was conducted on 8/7/2024 at 8:22 am with the Director of Nursing (DON). The DON stated if a resident was on oxygen, oxygen usage was displayed on the resident's vital signs in the Electronic Health Record (EHR). The DON stated the facility did not use oxygen signage outside of resident rooms because they had been told that was a violation of the resident's privacy.</p> <p>An interview was conducted on 8/7/2024 at 8:33 am with the Administrator. The Administrator stated that in the past, the facility would place a magnet outside of the resident's room if oxygen was in use but had stopped because they were told that was a privacy/dignity issue.</p> <p>e. Resident #48 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure with hypoxia.</p> <p>Review of Resident #48's most recent quarterly Minimum Data Set assessment dated [DATE] revealed resident to be moderately impaired. Resident #48 was coded as having shortness of breath with exertion and shortness of breath when lying flat. Resident #48 was coded as receiving oxygen therapy while admitted to the facility.</p> <p>Review of Resident #48's care plan last updated 07/19/24 revealed a care plan for: [Resident #48] has chronic respiratory failure and requires oxygen therapy. Interventions included to administer oxygen as ordered, ensure the [Resident #48's] oxygen supply is available at all times, and oxygen at 2 liters per minute via nasal cannula continuously - check oxygen saturations every shift and record results.</p> <p>Review of Resident #48's physician orders revealed the following order:</p> <p>- Oxygen at 2 liters per minute via nasal cannula continuously - check oxygen saturation every shift and record results, may titrate as needed to maintain oxygen saturation greater than 92%.</p> <p>An observation of Resident #48 completed on 08/04/24 at 12:34 PM revealed resident to be in her room. Resident #48 was observed with her nasal cannula on her face and was receiving oxygen from her room concentrator at 2 liters per minute. An observation of Resident #48's room and doorway revealed no documented signage indicating the use of oxygen in the room.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Central Continuing Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1287 Newsome Street Mount Airy, NC 27030	

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 - Some</p>	<p>An additional observation of Resident #48's room and doorway completed on 08/05/24 at 2:59 PM continued to revealed no documented signage that indicated oxygen was in use in the room.</p> <p>An interview with Nurse Aide #6 on 08/05/24 at 3:21 PM revealed she was aware the Resident #48 wore oxygen. She further reported she was unsure if the facility utilized oxygen in use signs and verified that there was not one in Resident #48's room or on her doorway.</p> <p>An interview was conducted on 8/7/2024 at 8:22 am with the Director of Nursing (DON). The DON stated if a resident was on oxygen, oxygen usage was displayed on the resident's vital signs in the Electronic Health Record (EHR). The DON stated the facility did not use oxygen signage outside of resident rooms because they had been told that was a violation of the resident's privacy.</p> <p>An interview was conducted on 8/7/2024 at 8:33 am with the Administrator. The Administrator stated that in the past, the facility would place a magnet outside of the resident's room if oxygen was in use but had stopped because they were told that was a privacy/dignity issue.</p>