STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345556	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deerfield Episcopal Retirement	1617 Hendersonville Road Asheville, NC 28803

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 - 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** Based on observations, record review, and staff interviews, the facility failed to provide safe oxygen tank storage for 1 of 5 residents reviewed for accident hazards (Resident #28). The findings included: Resident #28 was admitted on [DATE] with diagnoses including chronic kidney disease stage 4, Type 2 diabetes, anemia, and lumber stenosis. A physician's order for Resident #28 dated 11/14/25 indicated to provide oxygen via nasal cannula at 2 to 5 liters per minute to maintain comfort for shortness of breath. The quarterly Minimum Data Set (MDS) assessment on 5/22/26 for Resident #28 was coded for receiving oxygen therapy, and for wheelchair use. On 6/2/26 at 9:10 AM an observation of Resident #28's room revealed a portable oxygen tank (a metal cylinder 25 inches tall and 4.5 inches wide with a flow control regulator on top), on the floor leaned at an angle against a filing cabinet with the regulator touching the edge of a dresser directly next to it. The oxygen tank was in a spongy fabric holder which had straps for attachment to the resident's wheelchair. The oxygen tank's flow regulator was turned off, and the gauge indicator was in the space midway between one quarter full and empty. Resident #28 was asleep in bed, wearing an oxygen cannula connected to an oxygen concentrator. An empty rolling oxygen tank cart was seen in the room behind the entrance door. Observation was made of Resident #28's room on 6/2/26 at 10:20 AM and revealed the oxygen tank on the floor, leaned at an angle against the filing cabinet with the regulator touching the edge of the dresser directly next to it. The oxygen tank was in a spongy fabric holder which had straps for attachment to the resident's wheelchair. The oxygen tank's flow regulator was turned off, and the gauge indicator was in the space midway between one quarter full and empty. Resident #28 was asleep in bed and wearing an oxygen cannula connected to an oxygen concentrator. An empty rolling oxygen tank cart was seen in the room behind the entrance door. During a telephone interview on 6/3/26 at 9:01 AM, Nurse Aide (NA) #3 stated she had been Resident #28's NA the overnight shift 6/1/26 into 6/2/26. NA #3 explained sometime between 1:00 AM and 3:00 AM she went into Resident #28's room to get her wheelchair to weigh it which they did monthly for weight accuracy. She further explained Resident #28 was asleep in bed at the time and on oxygen connected to her oxygen concentrator. NA #3 revealed she removed the tank in its fabric holder from the wheelchair and set it on the floor next to the dresser then took the wheelchair out to weigh it. NA #3 stated when she brought the wheelchair back into Resident #28's room, as she was getting ready to reattach the oxygen tank to the wheelchair, another resident's call bell rang, and she left to answer it. NA #3 revealed she should have secured the oxygen tank in a rolling cart when removing the oxygen tank and she had known there was one in the room. She also stated she should have finished attaching the oxygen tank to the wheelchair before leaving to get the call bell and just didn't think about it and didn't notice the tank again when she went back in the room later in the shift. NA #3 stated she had been taught the importance of securing oxygen tanks for safety at orientation and the facility had plenty of rolling carts. An interview was conducted on 6/2/26 at 10:53 AM with Nurse Aide (NA) #2 who was Resident #28's day shift nurse aide. NA #2 revealed she had done walking rounds with the night shift aide, NA #3 at shift change about 6:50 AM. She explained it was dark in the room, but they (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	looked around and laid eyes on the resident who had been sleeping. NA #2 stated she thought she saw the oxygen tank on the back of the wheelchair where it usually was. She explained she did not see an oxygen tank on the floor and if she had she had she would have put it back on the wheelchair holder or in the rolling cart. NA #2 stated she knew there was usually a rolling cart in Resident #28's room for when they weighed her or changed out oxygen tanks. In an interview on 6/2/26 at 10:31 AM with NA #1 who was assisting NA #2 this shift, she stated when Resident #28 left her room with oxygen they would connect oxygen to the tank in the fabric holder on the back of her wheelchair. NA #1 explained when Resident #28 was brought back to her room, sometimes she would get back in bed, and they would switch her cannula to the oxygen concentrator. NA #1 further explained if Resident #28 stayed in her wheelchair they might leave her on the tank attached to her chair. NA #1 explained portable oxygen tanks lasted a few hours, and staff knew how to use the rolling cart when moving oxygen tanks. In an interview on 6/2/26 at 10:38 AM with Nurse #1, she stated she was Resident #28's nurse and had been in her room earlier and spoken briefly with her about 9:15 AM and again about 10:30 AM. Nurse #1 stated she did not notice any oxygen tank in her line of sight either time she had been in the room. Nurse #1 further explained oxygen tanks should not be sitting on the floor but should be in a rolling cart or attached to the wheelchair which was where Resident #28's tank was usually kept when she left the room. An interview was conducted with the Director of Nursing (DON) on 6/2/26 at 10:25 AM in Resident #28's room. The DON observed the oxygen tank leaning against the filing cabinet and revealed that was not how oxygen tanks should be stored and it should have been in a rolling cart for safety. She confirmed the oxygen level to be between 1/4 full and empty and the presence of a rolling oxygen tank cart in the room. The DON explained they had not had problems with oxygen tank storage and didn't know how this happened. She further explained the night and day shift nurse aides did walking rounds together at shift change between 6:45 AM and 7:15 AM and should have caught the unsecured tank in there. During a follow up interview with the DON on 6/3/26 at 9:12 AM she explained oxygen tanks were to be secured in a rolling cart or a bag hooked to the resident's wheelchair and were in a secure rack in the oxygen storage room. The DON indicated proper oxygen storage was taught to new staff in orientation. The DON revealed oxygen tanks cannot be outside the rolling cart whether full or empty because it could be a safety hazard if they were not secured. In an interview with the Administrator on 6/3/26 at 9:30 AM he stated they had not had problems with oxygen tanks before, and this was a case of human error. He explained the oxygen tank was under pressure and if it had fallen or got bumped there could have been safety consequences. The Administrator further explained the expectation was that oxygen tanks were properly and safely secured.