

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255159		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/24/2026	
NAME OF PROVIDER OR SUPPLIER PERRY COUNTY NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 202 BAY AVENUE WEST P O BOX 1620, RICHTON, Mississippi, 39476			
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F0000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification survey along with five (5) Complaint Investigations (CI MS #3175539, CI MS #3110634, CI MS #3119246, CI MS #3094522, and CI MS #3118904) at the facility from 9/21/26 through 9/24/26. CI MS #3175539 was investigated for misappropriation of property, quality of care, and resident rights, CI MS #3110634 was investigated for staffing, quality of care, abuse, and resident rights, CI MS #3094522 was investigated for abuse and quality of care, and CI MS #3119246 was investigated for quality of care, nursing services, falls, misappropriation of property, and falsification of records and there were no citations related to these complaint. CI MS #3118904 was a facility reported incident (FRI) that was investigated for accidents and F656 was cited. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F812, F836, F552, F641, F656, and F695. The facility had a census of 55 and was licensed for 60 beds.			F0000			
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.			F0812			

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 reverse for further 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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F0812 SS = E	Continued from page 1 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and facility policy review, the facility failed to store and maintain food under sanitary conditions by failing to: 1) discard prepared sandwiches by the facility-identified discard date; 2) ensure an opened food product was clearly dated to identify the applicable use-by date; and 3) identify and remove produce with visible biological growth from refrigerated storage, for one (1) of two (2) kitchen observations. Findings include: A record review of the facility's policy titled "Food Storage Labeling," revised 08/2024, revealed, "Procedure...4. Leftovers can be stored for only 3 days...5...labeling includes...b...Use by Date..." On 09/21/2026 at 10:12 AM, during an initial tour of the kitchen with the Dietary Manager (DM), an observation of refrigerator #2 revealed six (6) half peanut butter and jelly sandwiches and five (5) half pimento cheese sandwiches dated 09/16/2026. The DM stated the peanut butter and jelly sandwiches and pimento cheese sandwiches should have been discarded on 09/19/2026. During the continued kitchen observation, refrigerator #3 contained one opened bag of Parmesan cheese labeled with two dates, 02/23/2026 and 06/09/2026. The DM was unable to identify what either date represented. Refrigerator #3 also contained 11 tomatoes with visible biological growth. The DM stated all kitchen staff were responsible for maintaining food quality. On 09/24/2026 at 11:43 AM, during an interview, the Administrator stated she was aware of the produce with visible biological growth, the opened cheese with unclear dating, and the prepared food that had not been discarded by the identified discard date. The Administrator stated all dietary staff were responsible for maintaining food safety by monitoring refrigerated food, pantry food, and newly delivered food. The Administrator stated food that was not safe for consumption should not remain in the kitchen and expected dietary staff to conduct			F0812			

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F0812 SS = E	Continued from page 2 daily rounds to ensure food was safe.	F0812					
F0836 SS = E	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to ensure a licensed nurse designated as the charge nurse was separate from the medication/treatment nurse by assigning the medication/treatment nurse to also serve as the charge nurse from 4:30 PM to 11:00 PM during the 3:00 PM to 11:00 PM shift for one (1) of three (3) shifts reviewed for charge nurse supervision. Findings Include: A record review of the facility's policy titled	F0836					

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F0836 SS = E	Continued from page 3 "Nursing Services-Staffing," dated 02/2026, revealed, "...The facility will comply with established staffing requirements by the individual state governing agencies. Each facility will designate a nurse who holds an active license...as a Charge Nurse..." A record review of the "Daily Unit Assignment Form," dated 09/07/2026 through 09/20/2026, revealed no licensed nurse was designated as the Charge Nurse, separate from the medication/treatment nurse, from 4:30 PM to 11:00 PM. On 09/23/2026 at 11:46 AM, during an interview, the Director of Nursing (DON) stated she worked Monday through Friday from 7:00 AM to 4:30 PM and served as the Charge Nurse while on duty. The DON confirmed that when her shift ended at 4:30 PM, a medication cart nurse was assigned to serve as the Charge Nurse in addition to the medication cart nurse's assigned duties until 11:00 PM. The DON stated the importance of having a designated Charge Nurse was to assume supervisory duties while the medication cart nurse remained responsible for the medication cart. The DON stated the facility would have to hire a nurse to provide Charge Nurse coverage during the 3:00 PM to 11:00 PM shift. On 09/23/2026 at 11:54 AM, during an interview, Certified Nursing Assistant (CNA) #2 stated she typically worked from 7:00 AM to 3:00 PM but frequently worked during the 3:00 PM to 11:00 PM shift. CNA #2 stated that when she needed assistance from the Charge Nurse during the 3:00 PM to 11:00 PM shift, she went to the medication cart nurse assigned to serve as the Charge Nurse for that shift. On 09/23/2026 at 12:00 PM, during an interview, the Administrator stated she was unaware that the medication cart nurse could not also serve as the Charge Nurse. The Administrator stated the importance of having a designated Charge Nurse was for the management and supervision of nursing duties. The Administrator stated the facility would have to hire a Charge Nurse to provide coverage during the 3:00 PM to 11:00 PM shift.			F0836			
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and			F0552			

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F0552 SS = D	Continued from page 4 participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to ensure a resident or Resident Representative (RR) was informed of the risks, benefits, and alternatives associated with the use of an antipsychotic medication and afforded the opportunity to participate in the treatment decision prior to initiation of the medication for one (1) of five (5) residents reviewed for psychotropic medication use. Resident #6. Findings include: A record review of the facility's policy titled "Psychotropic Medications," revised 02/2025, revealed "...A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include...1. Anti-psychotic...Consent for Anti-psychotic...shall be completed..." A record review of Resident #6's "Face Sheet" revealed the facility admitted the resident on 04/10/2025 with diagnoses including Vascular Dementia, Severe with Other Behavioral Disturbance and Other Schizophrenia. A record review of Resident #6's "Order Summary Report" revealed an active physician's order dated 8/31/26 for Zyprexa 10 milligrams (mg), one tablet via percutaneous endoscopic gastrostomy (PEG) tube at bedtime related to Other Schizophrenia. A record review of Resident #6's "Discharge Return Anticipated Minimum Data Set (MDS)," with an	F0552			

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F0552 SS = D	Continued from page 5 Assessment Reference Date (ARD) of 09/09/2026, revealed the resident had short-term memory problems. A review of Section N revealed the resident received an antipsychotic medication. A record review of Resident #6's "Care Plan Report" revealed a focus for psychotropic medication use with interventions including Zyprexa 10 mg via PEG tube at bedtime and monitoring for adverse reactions associated with psychotropic medications. A record review of Resident #6's medical record revealed no documented evidence that the resident and/or RR was informed of the risks, benefits, and alternatives associated with Zyprexa or afforded the opportunity to accept or decline the medication prior to its initiation on 11/12/2025. On 09/22/2026 at 3:33 PM, during an interview, Licensed Practical Nurse (LPN) #1 stated Resident #6 received Zyprexa for dementia with outbursts. On 09/23/2026 at 2:35 PM, during an interview, the Director of Nursing (DON) stated psychotropic medication consents were obtained upon admission or prior to initiating a newly ordered psychotropic medication. The DON stated Social Services was responsible for obtaining consent for newly admitted residents, and the DON was responsible for obtaining consent for newly ordered psychotropic medications. The DON confirmed Resident #6 had received an antipsychotic medication since 11/12/2025 and no consent had been obtained from the resident or RR prior to initiation of the medication. The DON stated the purpose of the psychotropic medication consent was to inform the resident or family member of the potential side effects and reason for the medication.	F0552					
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification.	F0641					

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F0641 SS = D	Continued from page 6 §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interviews, and facility policy review, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected a resident's Preadmission Screening and Resident Review (PASRR) Level II determination when Section A1500 was coded "No" despite a State Level II PASRR determination that the resident met the criteria for having a mental illness as defined by PASRR, for one (1) of (14) residents reviewed for MDS accuracy. Resident #41. Findings include: A record review of the facility's policy titled "Resident MDS Assessment," revised 09/2019, revealed "...any healthcare professional that completes a portion of the assessment must sign and certify the accuracy of the portion of the assessment that they have completed..." A record review of Resident #41's "Face Sheet" revealed the facility admitted the resident on 07/11/2023 with diagnoses including Schizophrenia, Unspecified; Bipolar Disorder, Unspecified; Major Depressive Disorder, Recurrent, Mild; and Paranoid Schizophrenia. A record review of Resident #41's "Department of			F0641			

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F0641 SS = D	Continued from page 7 Mental Health Summary of Findings Report," dated 07/18/2023, revealed the State Level II PASRR process determined the resident met the criteria for having a mental illness as defined by PASRR. A record review of Resident #41's "Order Details" revealed orders for Haloperidol 5 milligrams (mg) dated 1/8/25, Seroquel (quetiapine fumarate) 300 mg dated 1/8/25 and Prozac (fluoxetine hydrochloride) 10 mg dated 8/3/26. A record review of Resident #41's "Annual Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 04/09/2026, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Section A1500, Preadmission Screening and Resident Review (PASRR), was coded "0—No," indicating the resident was not currently considered by the State Level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. A review of Resident #41's PASRR records revealed the 07/18/2023 Level II determination was the most recent State PASRR determination available when the Annual MDS was completed on 04/09/2026. No subsequent State PASRR determination changing or superseding the 07/18/2023 determination was identified. On 09/21/2026 at 1:18 PM, during an interview and record review, the Corporate Consultant reviewed Resident #41's 07/18/2023 PASRR Level II determination and Annual MDS with an ARD of 04/09/2026. The Corporate Consultant confirmed Section A1500 of the Annual MDS was inaccurately coded and should have been coded "1—Yes" because the State Level II PASRR process had determined the resident met the criteria for having a serious mental illness. On 09/23/2026 at 12:47 PM, during an interview, Licensed Practical Nurse (LPN) #2 stated he became aware of the MDS coding error after the survey team entered the facility. LPN #2 confirmed his name was documented as completing Resident #41's Annual MDS and stated he may have selected the incorrect response when completing the assessment. On 09/23/2026 at 12:54 PM, during an interview, Registered Nurse (RN) #1, Nurse Case Manager, stated she did not identify the inaccurate coding of Section A1500 during her review of Resident #41's Annual MDS. RN #1 stated she was unaware of the error until it was brought to her attention during the survey.			F0641			

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F0641 SS = D	Continued from page 8 On 09/24/2026 at 11:42 AM, during an interview, RN #1 stated each professional who completed a section of the MDS signed and certified that the section completed was accurate. RN #1 stated this certification process was how the facility verified the accuracy of MDS submissions.	F0641					
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements	F0656					

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F0656 SS = D	Continued from page 9 set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to implement comprehensive person-centered care plan interventions by failing to: 1) ensure continuous oxygen was administered to Resident #21 at the care-planned flow rate of two (2) liters per minute (L/min) via nasal cannula; and 2) use the care-planned sling and two-person assistance during a mechanical-lift transfer for Resident #40, for two (2) of (14) residents reviewed for comprehensive care plans. Residents #21 and #40. Findings include: A record review of the facility's policy titled "Care Plan Process," revised 12/2024, revealed "...the care plan must include measurable objectives and the timeframes and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being...The facility staff shall follow the care plan..." Resident #21 A record review of Resident #21's "Face Sheet" revealed the facility admitted the resident on 11/28/2024 with a diagnosis including Chronic Obstructive Pulmonary Disease (COPD). A record review of Resident #21's "Order Summary Report" revealed an active physician's order dated 8/27/24 for continuous oxygen at two (2) L/min via nasal cannula. A record review of Resident #21's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/30/2026, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Section O documented the resident received oxygen therapy. A record review of Resident #21's "Care Plan Report" revealed an intervention for continuous oxygen at two (2) L/min via nasal cannula.			F0656			

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F0656 SS = D	Continued from page 10 A record review of Resident #21's September 2026 Medication Administration Record (MAR) revealed an order for continuous oxygen at two (2) L/min via nasal cannula every shift related to COPD. The MAR documented staff administered the oxygen at the prescribed flow rate. On 09/21/2026 at 12:44 PM, during an observation, the State Agency (SA) observed Resident #21 sitting in a wheelchair in the resident's room receiving oxygen via nasal cannula. The oxygen concentrator was set at three (3) L/min. On 09/22/2026 at 3:15 PM, during an observation, the SA observed Resident #21 return to the resident's room following a smoke break and resume oxygen therapy. The oxygen concentrator was set at 3.5 L/min. On 09/23/2026 at 9:57 AM, during an interview and observation, Resident #21 stated that after returning from smoke breaks, she turned on the oxygen concentrator and applied the nasal cannula. Resident #21 stated she did not adjust the oxygen flow rate and only "flipped the switch" to turn the oxygen on. The resident demonstrated how she applied the nasal cannula and turned on the oxygen concentrator. The SA observed the oxygen concentrator set at 3.5 L/min. Resident #21 stated staff did not routinely check the oxygen flow rate throughout the day after she turned the oxygen on. On 09/24/2026 at 9:44 AM, during an interview, Registered Nurse (RN) #1, Nurse Case Manager, stated Resident #21's comprehensive care plan was accessible to Certified Nursing Assistants (CNAs) and other staff responsible for providing care. RN #1 stated resident-specific care information, including the prescribed oxygen flow rate, was documented in the comprehensive care plan for staff reference. On 09/24/2026 at 10:38 AM, during an observation, the SA observed Resident #21 in the resident's room receiving oxygen via nasal cannula. The oxygen concentrator was set at 3.5 L/min. On 09/24/2026 at 10:50 AM, during an observation with the Director of Nursing (DON), the SA observed Resident #21 receiving oxygen via nasal cannula with the oxygen concentrator set at three (3) L/min. The DON confirmed the resident's physician order specified continuous oxygen at two (2) L/min via nasal cannula. Resident #40			F0656			

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F0656 SS = D	Continued from page 11. A record review of Resident #40's "Face Sheet" revealed the facility admitted the resident on 11/30/2023 with a diagnosis of Chronic Obstructive Pulmonary Disease, Unspecified. A record review of Resident #40's "Annual MDS," with an ARD of 07/15/2026, revealed a BIMS score of 14, indicating the resident was cognitively intact. A record review of Resident #40's "Care Plan Report" with a date initiated of 11/30/23 revealed a focus for the resident's lifting plan with interventions including "red total-lift X (times) two (2)" and "regular sling medium." On 09/21/2026 at 12:27 PM, during an interview, Resident #40 stated she slid out of a mechanical-lift sling while being transferred from the bed to a chair during the previous month. Resident #40 stated she was not transferred to the emergency room following the incident and a nurse assessed her after the incident. On 09/22/2026 at 3:38 PM, during an interview, Certified Nursing Assistant (CNA) #1 stated the appropriate sling type could be identified by the color of the sling loops. CNA #1 stated information regarding the appropriate sling and required number of staff assisting with transfers was available in the resident's Kardex and care plan. On 09/23/2026 at 2:42 PM, during a telephone interview, the former employee who transferred Resident #40 during the 07/25/2026 incident stated she had provided care to the resident for approximately one week before the incident. The former employee stated she used the sling that was in Resident #40's chair and that the same sling had been used by the previous shift. The former employee recalled the sling was gray but did not recall the color of the sling loops. The former employee stated she had not received training regarding the different types of mechanical-lift slings or which sling was appropriate for Resident #40 before the incident. The former employee confirmed she was the only staff member transferring Resident #40 at the time of the incident. The former employee stated that after Resident #40 slipped from the sling, staff received an in-service and were instructed to use the correct sling for each resident. On 09/23/2026 at 3:40 PM, during an interview, the DON stated signage posted in resident rooms provided staff with information regarding whether residents required a mechanical lift or other transfer assistance, the appropriate sling, and other			F0656			

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F0656 SS = D	Continued from page 12 resident-specific care needs. On 09/24/2026 at 9:44 AM, during an interview, RN #1 stated Resident #40's comprehensive care plan was accessible to CNAs and other staff responsible for providing care. RN #1 stated resident-specific information, including the appropriate sling type and required number of staff assisting with transfers, was documented in the resident's comprehensive care plan for staff reference. On 09/24/2026 at 10:44 AM, during an interview, the DON stated the sling used to transfer Resident #40 on 07/25/2026 was a black small sling, although the resident's care plan directed staff to use a red medium sling with two-person assistance.	F0656					
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to ensure oxygen therapy was provided in accordance with physician orders and professional standards of practice by failing to: 1) administer continuous oxygen at the physician-ordered flow rate of two (2) liters per minute (L/min) via nasal cannula when Resident #21 was repeatedly observed receiving oxygen at flow rates ranging from 3 to 3.5 L/min; and 2) obtain an active physician's order specifying the prescribed oxygen therapy administered to Resident #10, for two (2) of (2) residents reviewed for respiratory care. Residents #21 and #10. Findings include: A record review of the facility's policy titled "Oxygen-Administration, Concentrator, Storage, Assemblage," revised 01/2024, revealed, "...Procedure 1. Obtain appropriate physician's order...Oxygen concentrator...2. Set the prescribed flow by turning the flow selector to the prescribed	F0695					

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F0695 SS = D	Continued from page 13 delivery rate..." Resident #10 A record review of Resident #10's "Face Sheet" revealed the facility admitted the resident on 12/01/2023 with diagnoses including Latent Tuberculosis and Shortness of Breath. A record review of Resident #10's "Progress Note," dated 09/12/2026 at 6:10 PM, revealed the resident experienced a weak spell and appeared pale. The resident's blood pressure was 75/53 millimeters of mercury (mmHg), heart rate was 82 beats per minute, and blood glucose was 212 milligrams per deciliter (mg/dL). The on-call medical provider was notified, and orders were received for laboratory testing, positioning the resident in bed with the legs elevated, and notification of the provider with the laboratory results. The note further revealed the resident's oxygen saturation was 86% on room air, and staff applied oxygen at two (2) liters per minute (L/min) via nasal cannula. The provider was subsequently notified of the resident's results and issued an order for one (1) liter of normal saline to be administered over two (2) hours. The note did not identify an order from the medical provider for oxygen therapy. A record review of Resident #10's "Order Summary Report" revealed no active physician's order for oxygen administration. A record review of Resident #10's "Annual Change Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 08/13/2026, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. On 09/22/2026 at 2:48 PM, during an observation, the State Agency (SA) observed Resident #10 lying in bed receiving oxygen therapy at two (2) L/min via nasal cannula. On 09/22/2026 at 3:16 PM, during an interview, Licensed Practical Nurse (LPN) #4 confirmed Resident #10 was receiving continuous oxygen at two (2) L/min via nasal cannula due to decreased oxygen saturation. LPN #4 confirmed no active physician's order for oxygen therapy was identified in the resident's medical record. On 09/22/2026 at 3:23 PM, during an interview and record review, the Director of Nursing (DON) stated Resident #10 was receiving oxygen therapy due to fluctuating oxygen saturation. The DON reviewed the	F0695			

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F0695 SS = D	Continued from page 14 resident's physician orders and confirmed there was no active physician's order for oxygen therapy. A record review of the September 2026 Medication Administration Record (MAR) revealed an order on the MAR for oxygen administration at 2 L/min and was dated 9/22/26. Resident #21 A record review of Resident #21's "Face Sheet" revealed the facility admitted the resident on 11/28/2024 with a diagnosis including Chronic Obstructive Pulmonary Disease (COPD). A record review of Resident #21's "Order Summary Report" revealed an active physician's order dated 8/27/24 for continuous oxygen at two (2) L/min via nasal cannula. A record review of Resident #21's Quarterly MDS, with an ARD of 07/30/2026, revealed a BIMS score of 15, indicating the resident was cognitively intact. Section O documented the resident received oxygen therapy. A record review of Resident #21's September 2026 Medication Administration Record (MAR) revealed an order for continuous oxygen at two (2) L/min via nasal cannula every shift related to COPD. The MAR documented staff administered the oxygen at the prescribed flow rate. On 09/21/2026 at 12:44 PM, during an observation, the SA observed Resident #21 sitting in a wheelchair in the resident's room receiving oxygen via nasal cannula. The oxygen concentrator was set at three (3) L/min. On 09/22/2026 at 3:15 PM, during an observation, the SA observed Resident #21 return to the resident's room following a smoke break and resume oxygen therapy. The oxygen concentrator was set at 3.5 L/min. On 09/23/2026 at 9:57 AM, during an interview and observation, Resident #21 stated that after returning from smoke breaks, she turned on the oxygen concentrator and applied the nasal cannula. Resident #21 stated she did not adjust the oxygen flow rate and only "flipped the switch" to turn the oxygen on. The resident demonstrated how she applied the nasal cannula and turned on the oxygen concentrator. The SA observed the oxygen concentrator set at 3.5 L/min. Resident #21 stated			F0695			

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F0695 SS = D	Continued from page 15 staff did not routinely check the oxygen flow rate throughout the day after she turned the oxygen on. On 09/23/2026 at 3:43 PM, during an interview, the DON stated that upon returning from a smoke break, Resident #21 either reapplied the oxygen independently or received assistance from Certified Nursing Assistants (CNAs). The DON stated she checked the resident's oxygen throughout the day to verify the oxygen was administered at the physician-ordered flow rate. On 09/24/2026 at 9:45 AM, during an interview, LPN #3, PRN Medication Cart Nurse, stated she checked residents' oxygen concentrator flow rates while administering medications and compared the flow rates with the physician orders documented on the MAR. LPN #3 stated that if an oxygen flow rate did not match the physician-ordered rate, she adjusted the concentrator to the prescribed setting and reported the discrepancy to the DON. On 09/24/2026 at 10:38 AM, during an observation, the SA observed Resident #21 in the resident's room receiving oxygen via nasal cannula. The oxygen concentrator was set at 3.5 L/min. On 09/24/2026 at 10:50 AM, during an observation with the DON, the SA observed Resident #21 receiving oxygen via nasal cannula with the oxygen concentrator set at three (3) L/min. The DON confirmed the resident's physician order specified continuous oxygen at two (2) L/min via nasal cannula. The DON stated Resident #21 sometimes increased the oxygen flow rate after returning from smoke breaks. The SA informed the DON that during the SA's observation on 09/22/2026 following the resident's return from a smoke break, Resident #21 applied the nasal cannula and turned on the oxygen concentrator without adjusting the flow rate. The DON stated she expected Resident #21's oxygen to be administered at the physician-ordered flow rate of two (2) L/min and stated the facility planned to increase staff monitoring of the resident's oxygen flow rate to ensure it remained at the prescribed rate.			F0695			