STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145598	A. Building B. Wing	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seminary Manor	2345 North Seminary Street Galesburg, IL 61401

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31682 Based on observation, interview, and record review the facility failed to develop and implement pressure relieving interventions to prevent pressure ulcer development and worsening, conduct a pressure ulcer risk assessment once a week for four weeks after admission, obtain a treatment for a newly identified pressure ulcer, and accurately and thoroughly assess pressure ulcers weekly for two of three residents (R1 and R2) reviewed for facility acquired pressure ulcers in the sample of five. These failures resulted in R1 developing an unstageable pressure ulcer to the left heel six days after admission to the facility and R2 developing a stage three pressure ulcer to the right heel and an unstageable pressure ulcer to the inner ankle that required autolytic debridement (using own body's enzymes to remove dead tissue) and caused R2 severe pain. Findings include: (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	The facility's Pressure Injury/Pressure Ulcer Prevention and Treatment Protocol dated 10-24-22 documents Objective and Purpose: To ensure that measures are taken to prevent skin breakdown and to provide guidelines for treatment of any pressure injury or pressure ulcer that might develop. Pressure Ulcer/Injury refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin and may be painful. A pressure injury will present as an open ulcer. The appearance of which will vary depending on the stage and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. Soft tissue damage related to pressure and shear may also be affected by skin temperature and moisture, nutrition, perfusion, co-morbidities, and condition of the soft tissue. Principles: 1. A skin assessment is completed on all residents upon admission and weekly for the first four weeks after admission, quarterly, and whenever there is a change in the resident's condition. 2. An individualized plan of care will be developed for the resident following the guidelines of the assessment. 3. All high and moderate risk residents will be assessed for the needs of the items below. If the intervention is initiated, it will be added to the care plan. A. Special mattress and wheelchair cushions. B. PROMS (Passive Range of Motions). C. Protein and/or Nutritional Supplements. D. Turning and positioning schedule. E. Skin Checks. F. Elbow/heel protectors/bridging of heels. 6. When a resident is admitted to the facility or develops a pressure injury in the facility, the following will occur: A. Assess the pressure injury for location, size, wound bed, drainage, odor, tunneling, undermining or sinus tract, wound edges/surrounding tissues, and pain at site. B. Determine the injury's current stage of development: Stage One Pressure Injury: Non-blanchable erythema of intact skin. Stage Two Pressure Ulcer: Partial thickness skin loss with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink, or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not viable. Granulation tissue, slough, and eschar are not present. Stage Three Pressure Ulcer: Full thickness loss of skin, in which subcutaneous fat is visible in the ulcer and granulation tissues are epibole (rolled wound edges) are often present. Slough and or/eschar may be visible but does not obscure the depth of tissue loss. If slough or eschar obscures the wound bed, it is an unstageable pressure ulcer/pressure injury. Unstageable Pressure Ulcer: Full-thickness ski and tissue loss in which the extent of tissue damage with the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. Stable eschar (dry, adherent, intact without erythema or fluctuance) should only be removed after careful consideration and consultation with the resident's physician, or nurse practitioner, physician assistant, or clinical nurse specialist. Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon, or purple discoloration due to damage of underlying soft tissue, this area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue, This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. C. Notify the physician of the above assessment and obtain orders for treatment of pressure ulcer/injury. If pressure ulcer/injury is showing no improvement, Physician will be notified so change of treatment may be obtained, E. Care plan will be established for treatment of existing pressure ulcers/injuries. G. For pressure ulcer with drainage the physician will be notified, and culture obtained if ordered. Pressure Injury and Treatment Protocol: H. Weekly measurements will be conducted and entered in the chart under wound management. J. Turning and repositioning assistance will be given to those residents that are unable to reposition themselves. K. Special devices will be used to relieve pressure, L. All treatment and charting of pressure ulcers/injuries will be done by licensed staff. R1's Admission Record documents R1 was a [AGE] year-old admitted to the facility on [DATE] with the diagnoses of a Left Femur Fracture, Abnormalities of Gait and Mobility, Lack of Coordination, and Weakness. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R1's Procedure and Surgeon Notes dated 12-2-24 document R1 received a left hip open reduction internal fixation with intramedullary implant repair to repair R1's left hip fracture. R1's Braden Scale for Predicting Pressure Sore Risk assessment dated [DATE] (Admission) and 12-31-24 document R1 was at risk of developing a pressure ulcer. R1's MDS (Minimum Data Set) assessment dated [DATE] documents R1 was cognitively intact and had no pressure ulcers on admission (12-5-24). This same MDS Assessment documents R1 developed a facility acquired stage II pressure ulcer. R1's Medical Record does not include evidence of a Braden Scale being completed every week for four weeks after R1's admission, as instructed by the facility's Pressure Injury/Pressure Ulcer Prevention and Treatment Protocol. R1's Progress Notes dated 12-11-24 and signed by V5 (Prior Director of Nursing) document, While dressing (R1) for the day (CNA/Certified Nursing Assistant) notified this nurse of area to (R1's) left heel. Area is a 3.5 cm (centimeter) by 3.7 cm fluid filled blister, not draining, surrounded by pink normal skin. Area cleansed, skin prepped, and border foam applied for protection. Foot floated while CNA finished dressing (R1). Recommendation to continue above treatment and apply moon boot forwarded to (Clinic). R1's Hospital Discharge Summary dated 12-31-24 documents, (R1) was noted to have a left heel blackish blister upon admission (hospital admission 12-23-24). Likely 2/2 deep tissue injury (full-thickness deep tissue injury) causing some localized bleeding resulting in a blood blister. ABI (Ankle-Brachial Index) normal to left lower extremity. R1's Progress Notes dated 1-12-25 and signed by V6 (Wound Nurse) document, (R1's) wound measurement area to (R1's) L (left) heel. Area is a 4 cm x 5 cm fluid filled blister, not draining, surrounded by pink normal skin. Area cleansed, skin prepped, and border foam applied for protection. Foot floated while CNA finishes dressing (R1). The facility's Weekly Wound Reports dated 12-18-24, 12-25-24, and 1-8-25 document R1's wound to the left heel as a stage one Pressure Injury. The facility's Weekly Wound Report and R1's Medical Record/Progress Notes do not include a weekly assessment of R1's wound to the right heel for the week of 1-1-25 through 1-7-25. R1's Care Plan dated 12-5-24 (Admission) through 1-14-25 (Discharge) documents, Problem: (R1) is at increased risk for pressure ulcers related to decreased mobility and generalized muscle weakness following recent illness and hospitalization . Goal: (R1) will have decreased risk for skin breakdown during this quarter. Interventions: Assist (R1) with turning and re-positioning. Pressure reducing device in wheelchair and bed. Provide incontinence care after each incontinent episode. Therapy as ordered. This same care plan does not include R1's new onset of a pressure ulcer to the left heel with goals or interventions to treat and prevent the left heel pressure ulcer from declining or prevent further pressure ulcer development. R1's Progress Notes dated 1-15-25 document R1 was discharged to another long-term care facility per the family's request. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 1-28-25 at 9:37 AM V8 (R1's Family Member) stated, Anytime I would visit (R1) when she was admitted to the facility, she would not have a heel boot on. On 1-29-25 at 9:10 AM R1 was living in another long-term care facility and was interviewed by phone. R1 stated, I broke my right hip and could not move my leg on my own while in bed. I could not feel my heels at all due to the swelling. The staff never elevated my feet off the bed, and I did not get those jelly filled (heel protection) boots until after I got the sore to my left heel. I did not wear shoes while in bed or while in the recliner. When I was in the recliner my heels would be lying on the footrest. On 1-29-25 at 9:45 AM V6 (Wound Nurse) stated, I categorized (R1's) left heel pressure ulcer as a stage one throughout (R1's) stay here. I did not know if a pressure ulcer was black or purple that it was considered unstageable. I have not had a lot of wound training. There were a lot of staff off around Christmas, so no wounds got assessed from 12-25-24 through 1-7-25. On 1-29-25 at 1:50 PM V16 (Care Plan Coordinator) stated, I am sorry. I am behind a month on care plans. (R1's) Care Plan was never updated to include pressure relieving interventions to prevent pressure ulcers to (R1's) heels and was never updated once (R1) developed a new pressure ulcer to the left heel with goals to prevent the pressure ulcer from worsening and prevent further pressure ulcers. On 1-29-25 at 2:10 PM V7 (Nurse Practitioner) stated, (R1's) pressure ulcer to the left heel was probably caused by pressure when (R1) would be sitting in her recliner. When sitting in the recliner, (R1's) heels would by lying on the footrest. On 1-29-25 at 2:18 PM V15 (Prior DON/Director of Nursing) stated, (R1) was in bed quite a bit and did not have a wound to her heel on admission. (R1's) heels would be on the bed and that is what caused the pressure ulcer to (R1's) right heel. (R1) had a broken left hip. On 12-11-24 a CNA found a wound to (R1's) left heel and reported it to me. I assessed the wound and noted the wound to be a 3.5 cm by 3.7 cm fluid filled unstageable blister caused by pressure. On 1-29-25 at 2:30 PM V10 (MDS Coordinator) stated, I am responsible for completing the Braden Scale Assessments and I have been behind. (R1) was supposed to have a Braden Score completed on admission and every week for four weeks after admission. (R1) only had a Braden Scale Assessment completed on admission and did not have one completed for the next three weeks after admission. On 2-3-25 at 10:00 AM V17 (Therapy Director) stated, When (R1) had admitted here the beginning of December 2024 (R1's) legs were so heavy from the fluid build-up. (R1) could not lift her legs or feet up off the bed by herself. (R1) also had groin pain whenever trying to lift her legs up. (R1) needed moderate assistance of staff to raise her legs and feet off the bed and turn and re-position while in bed. 2. R2's current Physician's Orders document R2 has the diagnoses of Chronic Congestive Heart Failure and Cerebrovascular Disease. R2's MDS Assessments dated 11-25-24 and 12-5-24 document R2 is severely cognitively impaired and had no pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R2's Braden Scale for Predicting Pressure Sore Risk assessment dated [DATE] (Admission) documents R2 was not at risk of developing pressure ulcers. R2's Braden Scale for Predicting Pressure Sore Risk assessment dated [DATE] documents R2 was at high risk of developing pressure ulcers. R2's Care Plan dated 11-18-24 (Re-admission to facility) through 12-12-24 (date of pressure ulcer development to right heel) does not include pressure ulcer relieving interventions to prevent pressure ulcer development once R2 was identified by the Braden Scale for Predicting Pressure Sore Risk Assessment (dated 11-18-24) as being at high risk of developing pressure ulcers. R2's Event Details and Progress Notes dated 12-12-24 and signed by V6 (Wound Nurse) documents, Pressure Injury to Right Heel. Orders: Right heel cleanse area, apply Medi-honey and mepilex to be changed daily. (R2) has an area on his right heel that measures by 5 cm x 4 cm. R2's Medical Record dated 12-12-24 only includes a measurement of R2's newly developed right heel pressure ulcer and does not include any further description of the pressure ulcer's wound bed, drainage, odor, tunneling, undermining or sinus tract, or wound edges/surrounding tissues. The facility's Weekly Wound Report and R2's Medical Record/Progress Notes do not include a weekly assessment of R2's wound to the right heel for the week of 1-1-25 through 1-7-25. R2's Wound Management Progress Notes dated 1-22-25 and signed by V6 document, (R2) has an area on his right heel that measures 2.4 cm by 3.4 cm and an area to his right medial ankle measuring at 2.4 cm by 2. 0 cm. Both have serosanguinous (drainage of blood and serum) drainage between minimal and moderate. Both Stage II. R2's Medical Record does not include documentation of V4 (R2's Physician) being notified of R2's pressure ulcers having drainage or an order to treat the newly developed pressure ulcer to R2's right inner ankle on 1-22-25. R2's Physician's Order and Treatment Administration Records dated 1-22-25 through 2-4-25 do not include a physician's order to treat R2's right inner ankle pressure ulcer or evidence of a treatment being performed to R2's right inner ankle pressure ulcer. R2's Wound Visit Notes dated 2-5-25 and signed by V19 (Clinical Wound Care Nurse) document, Wound Right, Medial Heel is a Stage Three Pressure Ulcer acquired on 12-12-24 and had received a status of not healed. Initial wound encounter measurements are 2 cm length by 1.2 cm width, by 0.3 cm depth. There is a moderate amount of drainage noted. Wound bed had 76-100 percent granulation (healing tissue), 1-25 percent slough (dead tissue). Debridement Performed: Autolytic. Wound Right, Medial Ankle is an Unstageable Pressure Injury obscured full-thickness skin and tissue loss. Pressure ulcer acquired on 1-22-25 and had received a status of non-healed. Initial wound measurements are 2 cm length by 1.5 cm width by 0.3 cm depth. There is a moderate amount of serous drainage noted. Wound bed had 1-25 percent granulation, 76-100 percent slough, Debridement performed: Autolytic. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 1-29-25 at 9:50 AM R2 was lying in bed with a cushioned heel protecting boot to R2's right foot. R2's left foot was lying directly on the bed. R2 had an uncovered pressure ulcer to the right inner ankle and a dressing dated 1-28-25 to the right heel. V6 (Wound Nurse) removed the dressing to R2's right heel and measured both pressure ulcers to R2's right heel and right inner ankle. R2's right inner ankle pressure ulcer measured 2.3 cm by 2.7 cm and was covered in 100 percent slough with a moderate amount of serosanguinous drainage. R2's right heel pressure ulcer measured 1.6 cm x 2 cm with 50 percent granulation tissue and a moderate amount of serosanguinous drainage. V6 proceeded to cleanse both pressure ulcer with normal saline, applied Medi honey, and covered with gauze. During the treatment R2 was hollering out in pain stating, My foot hurts! My foot hurts! On 1-29-25 at 10:00 AM V6 (Wound Nurse) stated, I noticed (R2) had a new pressure ulcer to the right inner ankle last week (1-22-25). The right inner ankle wound had drainage last week but did not look this bad and I do not remember the wound having slough last week. (R2) usually always has pain when I change his dressings. I do not recall if the physician was notified of (R2's) wounds to the right heel and right inner ankle having drainage. I have caterogorized both of (R2's) pressure ulcers to the right foot and right inner ankle as stage two's. On 2-10-25 at 9:20 AM V6 stated, There is no documentation of a treatment order being obtained to (R2's) right ankle pressure ulcer or documentation of a treatment being performed to (R2's) right ankle pressure ulcer on (R2's) treatment administration record. On 2-10-25 at 11:00 AM V4 (Physician) stated, Both of (R1) and (R2) heels should have had off-loading to prevent the pressure ulcers from developing. That is basic to prevent pressure ulcers. Around three months ago the wound nurse was very active there about letting me know if there were changes to wounds. For the past three months I have not had a lot of communication with the facility about the residents' pressure ulcers. (R1's) pressure ulcer should not have been categorized as a stage one. (R1's) pressure ulcer to the heel would have been an unstageable pressure ulcer. (R2's) pressure ulcer to the right inner ankle should have been categorized as unstageable.

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F 0695 Level of Harm - 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** 31682 Based on record review and interview, the facility failed to monitor the level of Oxygen in a portable Oxygen tank for a resident diagnosed with Congestive Heart Failure, ensure a continuous Oxygen supply was administered as ordered by the Physician, and failed to perform an assessment after a resident went without Oxygen and experienced respiratory distress and a low pulse oximetry reading for one of three residents (R1) reviewed for Oxygen use in the sample of five. These failures resulted in R1 being without oxygen for 20 minutes on one occurrence and 10 minutes on second occurrence, which caused R1 to experience chest pain, shortness of breath, feelings of being smothered and imminent death. Findings include: The facility's Oxygen Therapy and Safety policy dated 4-9-20 documents Area: Nursing. It is the policy of this facility to provide a safe environment for residents, staff, and the public. Purpose: To provide a source of oxygen to persons experiencing an insufficient supply of same and to address the use and storage of oxygen and oxygen equipment. Staff responsible: Director of Nursing, Staff Nurse, Nurse Aides. Oxygen Therapy: M. D. (Medical Doctor) will provide: When to use, how often, liter flow, and whether to use cannula or mask. Document date, time, flow rate, frequency, and results of oxygen therapy in medical record. Address use of oxygen in care plan. Oxygen in Use: Licensed staff using oxygen equipment will be trained in its operation, safety precautions, and manufacturer's instructions for using equipment. R1's Admission Record documents R1 was a [AGE] year-old admitted to the facility on [DATE] with the diagnoses of a Congestive Heart Failure, Weakness, Chronic Obstructive Pulmonary Disease, Acute and Chronic Respiratory Failure with Hypoxia, Dependence on supplemental oxygen, Atrial Fibrillation, and Chronic Fatigue. R1's MDS (Minimum Data Set) Assessment documents R1 was cognitively intact. R1's Physician's Orders dated 12-5-25 through 12-7-24 document, Oxygen at five liters per nasal cannula continuously for Shortness of Breath. R1's Physician's Orders dated 12-7-25 through 12-23-24 document, Oxygen at four liters per nasal cannula continuously for Shortness of Breath. Oxygen Saturation every shift-titrate oxygen to maintain above or equal to 90% (percent). R1's Physician's Orders dated 1-3-25 through 1-10-25 document, Oxygen at five liters per nasal cannula continuously. R1's Physician's Order dated 1-10-25 and signed by V14 (Pulmonologist) document, Keep (R1) at six liters of oxygen. May titrate to keep oxygen saturation above 89%. R1's Nephrology Physician's Progress Notes dated 1-6-25 and signed by V8 (R1's Nephrologist) documents, (R1) has not been brought in with her required amount of supplemental oxygen with oxygen saturations around 80 percent. (continued on next page)

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F 0695 Level of Harm - Actual harm Residents Affected - Few	R1's Care Plan from admission (12-5-24) to discharge (1-14-25) does not address R1's oxygen needs or goals. R1's Progress Notes do not include any documentation of an assessment performed after R1 went without oxygen on 1-6-25 or any other occurrences of R1 going without her physician ordered oxygen. R1's Progress Notes dated 1-15-25 document R1 was discharged to another long-term care facility per the family's request. On 1-28-25 at 9:37 AM V13 (R1's Family Member) stated, On 1-6-25 I met (R1) and (V12/Transport) at (V8's) office. Upon arrival, I questioned how much oxygen was available. The driver (V12) replied they had one oxygen unit. I expressed this was inadequate for (R1's) needs. (V12) told me to call if (R1) needed more oxygen. When in (V8's) office I noticed (R1's) oxygen tank was empty. The staff came in and (R1's) pulse oximetry was 80 percent and (R1) was cyanotic, slurring her words, and complaining of back and arm pain. (V8's) instructions were to take(R1) to prompt care. (V8's) secretary stated that she had called (V12) and was told (V12) was filling an oxygen tank right then. From the time (V8's) secretary called for more oxygen to when (V12) came with the oxygen was 20 minutes. During dinner on 1-12-25 (R1's) oxygen tank again went empty. It was empty for more than ten minutes. (R1) started to become symptomatic. Another resident's family member (V9) noticed (R1) in distress and went to get a nurse. The nurse returned without an oxygen tank. After what was described as what seemed like a long time an unknown CNA returned with a replacement oxygen tank. No vital signs were recorded in (R1's) medical record and no progress or assessment was made about the occurrence. I was scared for (R1's) life while she was at that facility, and we decided to move (R1) to a different facility. On 1-28-25 at 2:15 PM V12 (Transport) stated, I am not certified. On 1-6-25 I took (R1) to her appointment with (V8). (V13/R1's Family Member) road with me in the van to the appointment. I took one portable oxygen tank with us to the appointment. (V13) told me I should take two tanks. I spoke to a nurse, and she told me I only needed one oxygen tank. I do not remember what nurse I spoke to. I filled (R1's) tank before the appointment. I dropped (R1) off for her appointment and went back to the facility. Around an hour to an hour and a half later, I got a call from the receptionist at (V8's) office saying I needed to get to their office fast because (R1) ran out of oxygen and was having a hard time breathing. I got a new oxygen tank and went to (V8's) office. (V13) was outside and waiting on me. I disconnected (R1's) oxygen tubing from the empty tank and attached the oxygen to the new tank. I turned the dial to five liters as that is what (V8) said (R1) needed. I brought (R1) back to the facility and a CNA took (R1) to her room. Some of the portable oxygen tank's gauges do not work. On 1-29-25 at 9:10 AM R1 was living in another long-term care facility and was interviewed by phone. R1 stated, I ran out of oxygen three or four times while living at that nursing home (the facility). One time at suppertime, I started to feel funny and checked my oxygen tubing. No oxygen was coming out. No staff were in the dining room, so I asked a visitor who was in there to go get me help. I felt like I was going to pass out and started having chest pain. It is the worst feeling when you cannot breathe. I was short of breath and felt like I was being smothered. It felt like forever before someone got me an oxygen tank. I was lucky the visitor was there to help me. When I went to the doctor (1-6-25) I was in the office and my oxygen tank ran out. I started turning purple and my eyes were twitching. I had chest pain. My son (V13) kept telling me to deep breath. I don't know what it feels like to die, but I know I felt close to it that day. It took 30 minutes for the facility to get me oxygen. The staff did not make sure I always had oxygen. (continued on next page)

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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 - Actual harm Residents Affected - Few	On 1-29-25 at 10:40 AM V9 (Visitor) stated, I was in a private dining room on 1-12-25 with my parents and another resident (R1). (R1) was the only other resident in this dining room. There were no staff present in this dining room. (R1) told me, I need help! (R1) was panicked and having a hard time breathing. I went and found a staff member and told them (R1) needed oxygen. (R1) was trying to deep breath and it looked like (R1) was struggling to breath. It took a nurse around ten minutes to get (R1) oxygen. It really scared me. On 1-29-25 at 11:05 AM V20 (Oxygen Supply Company Representative) stated, The portable oxygen tanks are older and some of the gauges do not work properly and the tanks do not have the volume to fill completely, making them not last as long as they should. If a patient is on five liter of oxygen, an oxygen concentrator should really be used to prevent a patient from running out of oxygen. On 1-29-25 at 2:10 PM V7 (Nurse Practitioner) stated, (R1) should not have run out of oxygen with her diagnoses. Running out of oxygen would cause (R1) to become short of breath and her pulse oximetry to drop. (R1) should have been on an oxygen concentrator and not on a portable oxygen tank. On 1-29-25 at 2:18 PM V15 (Prior DON/Director of Nursing) stated, I was not aware of (R1) running out of oxygen or experiencing shortness of breath or other symptoms from running out of oxygen. If (R1) went without oxygen a nurse should have done an assessment of (R1) and documented the occurrence in (R1's) progress notes. On 1-29-25 at 2:40 PM V21 (CNA/Certified Nursing Assistant) stated, We (facility staff) really do not have a set schedule on when to check residents to make sure their oxygen tanks are full. I just check periodically, and if the oxygen tanks are empty I fill them. The portable oxygen tanks do not last long. On 1-30-25 at 11:55 AM V14 (Pulmonologist) stated, I saw (R1) in my office and (R1) was very upset and said she ran out of oxygen several times. (R1) is [AGE] years old and requires supplemental oxygen at all times. (R1) has multiple heart concerns and has Chronic Obstructive Pulmonary Disease, Valvular Heart Disease, and Congestive Heart Failure. At absolutely no time should (R1) have ran out of oxygen. There is no excuse that the facility could have for (R1) to go without oxygen at any time. Any amount of time that (R1) would go without oxygen could result in (R1's) oxygen levels dropping and would be devastating and detrimental to (R1's) health. It could result in (R1's) death. (R1's) oxygen saturations should never drop below 89 percent.