STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105632	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at Harts Harbor	11565 Harts Rd Jacksonville, FL 32218

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure residents' right to a safe, clean, comfortable and homelike environment, including but not limited to, receiving treatment and supports for daily living safely for 14 (Residents #17, #22, #29, #75, #89, #59, #48, #23, #53, #1, #71, #34, #101 and #67) residents in 11 (Rooms #1, #2, #3, #4, #6, #8, #9, #10, #11, #15 and #21) of 65 resident rooms currently in use, and in both of the hallways (East and South) in the facility.The findings include: On 3/30/26 at 10:30 AM, a tour of the facility began. On 3/30/26 at 10:47 AM, room [ROOM NUMBER], occupied by Residents #17 and #22, was observed with a door frame that was missing multiple chucks of wood. In the bathroom, the floorboard behind the toilet was noted to be separated from the wall and was lying on the floor. Next to the sink, another floorboard was partially separated from the wall. Dark brown/black stains were observed throughout the tiles on bathroom floor. There were multiple holes, chips, and cracks along the top of the frame of the closet. Miscellaneous debris and brown flakes were covering the windowsill located next to Bed B. (Photographic evidence obtained) On 3/30/26 at 10:51 AM while conducting an interview with Resident #29 in room [ROOM NUMBER] Bed B, a live cockroach ran across the floor and behind a dresser in front of Bed A. Resident #29 stated she had seen roaches in the room before. She stated they were on her roommate's (Bed A's) side of the room. Other live roaches were observed on the floor and wall near the back of the dresser. (Photographic evidence obtained) On 3/30/26 at 11:03 AM, room [ROOM NUMBER], occupied by Residents #75 and #89, was observed with multiple red/brown stains on the floor. The windowsill contained debris, multiple miscellaneous items and insect carcasses. Red/brown stains were observed on the bottom of the window. Multiple red/brown stains were observed on the ceiling and the trim. The trim was noted to be cracked, stained, and separated from the ceiling. (Photographic evidence obtained) On 3/30/26 at 11:30 AM room [ROOM NUMBER], occupied by Residents #59 and #48, was observed. Upon entering the room, a foul odor was noted. A wheelchair that was tucked next to Bed A's closet had multiple items piled on top of it including incontinence padding, hygiene products, sterile medical supplies, a blanket, pads, washcloths and a pillow. A bottle of sterile water was observed on Bed A's TV stand. The contents were over half empty. There was no 'open date' on the bottle. A trashcan was observed next to Bed B with no liner in place. A rolled-up plastic glove and a plastic straw were observed on the floor next to the trashcan. Miscellaneous debris and brown flakes were covering the windowsill. Another plastic glove was observed next to the bedside table. The floorboards were cracked and had a brown substance covering them. There were multiple re/brown stains and several (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	miscellaneous brown and black flakes and clumps on the floor. An oxygen mask was observed under Bed B, a trash bag filled with linen was sitting on the floor and another trash bag containing a purple cloth was stuffed behind the dresser. (Photographic evidence obtained) On 3/30/26 at 11:30 AM, an observation was made of room [ROOM NUMBER], occupied by Resident #23. [NAME] stains were observed on the floor next to the window. The wall under the windowsill had multiple cracks. The floorboard was covered with brown stains and debris. The windowsill contained debris, multiple miscellaneous items and insect carcasses. The bathroom had towels on the floor in the corner with a broom on top of them. There was a bedside commode in the bathroom with an unidentified green object inside of it. A laundry basket of hygiene products was observed under the commode. Chipped paint was observed behind the toilet next to the floorboard. (Photographic evidence obtained) On 3/30/26 at 11:34 AM, Resident #53 was interviewed in his room, room [ROOM NUMBER]. He stated he required minimal assistance from staff. He was able to perform all activities of daily living (ADLs) independently. During the interview, several environmental concerns were observed. There was miscellaneous debris and brown flakes covering the windowsill. The window blinds were bent and broken. Both call bells were on the floor and wrapped around two additional cords in between Bed A and Bed B. The bathroom light would not turn on. Resident #53 stated it had been like that for a while and the facility needed to put in a new lightbulb. A pink bin was observed on the floor in the bathroom in between the sink and the toilet. Multiple rags with brown stains were wadded in the sink. [NAME] stains following a splatter pattern were observed on the wall and the handrail next to the toilet. A pair of shoes was observed under Bed A next to a pool of brown liquid. (Photographic evidence obtained) On 3/30/26 at 2:50 PM, an observation was made of room [ROOM NUMBER], occupied by Residents #1 and #71. A urinal containing a yellow liquid was observed on the bedside table. Red/brown stains were noted on the wall in a splatter pattern. The windowsill contained debris, multiple miscellaneous items and insect carcasses. [NAME] and black flakes covered the room's air conditioning unit. A disposable razor was observed sitting on the resident's table. The call bell was on the floor. (Photographic evidence obtained) On 3/31/26 at 10:04 AM, multiple brown stains with splatter and streak patterns were observed under the window in room [ROOM NUMBER]. A collection of miscellaneous black and brown flakes was observed along the floor panel in the corner of the room next to the air conditioning unit, and on the air conditioning unit. Several large cracks were observed in the wall where the air conditioning unit met the windowsill. A section of the ceiling trim had dislodged from the ceiling and there were multiple large stains observed on the ceiling. A trash bag containing miscellaneous items was observed on the floor. (Photographic evidence obtained) Upon exiting room [ROOM NUMBER], exposed pipes were observed in the ceiling covered with a thick black substance. The pipes extended the length of the East Hall where rooms #1, #2, #3, #4, #5 and #6 were located. Cracked and peeling paint was observed throughout the ceiling. (Photographic evidence obtained) On 3/31/26 at 10:21 AM, an interview was conducted with Resident #34 in his room. During the interview multiple brown stains were observed on the wall and the floor under the windows on the far side of the room. An unidentified blue wrapper was observed on the floor under the window. A black electrical cable was found on the floor on the far side of the room. The end of the cable was loosely wrapped in a circle on the floor and did not connect to anything. (Photographic evidence obtained) (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 3/31/26 at 2:00 PM with Housekeeper C who stated she worked five days a week from 7:00 AM to 2:00 PM. She stated she got her daily assignment from the manager and that there were usually two housekeepers assigned to each hall. She stated she had the same daily routine. Each room was swept and mopped. The housekeepers cleaned the bed rails, the blinds, the toilets, sinks, paper towel holders, behind the toilet seats, and mopped the floor in every room every day. She stated the windowsills and A/C vents were to be cleaned daily. When she was asked to describe the protocol when pests were sighted, she stated it would be reported to the manager then reported electronically to maintenance. On 3/31/26 at 2:21PM, an interview was attempted with Resident #101 in his room, room [ROOM NUMBER]. The resident was nonverbal and unable to be interviewed. While in the resident's room several crawling insects were observed on the floor next to the resident's bed. Insects were also observed flying near the floor and the resident's bed. The resident's personal belongings were in cardboard boxes in a chair next to the bed. [NAME] stains were observed on the floor along the wall behind the bed. Several small ants were crawling near the call light box located behind the head of the resident's bed. The resident made nonverbal gestures and pointed. He was advised to press his call light for assistance. The call light was pressed but did not illuminate outside of the resident's doorway. An interview was conducted on 3/31/26 at 2:24 PM with the Maintenance Director. He was asked about the facility's pest control protocol and replied that the pest control company came to the facility every two weeks. He stated if there were sightings, staff should notify him or document the sightings in the book at the nurses' station. He stated he was not aware of any concerns. He was accompanied to Resident #101's room (room [ROOM NUMBER])and upon entering the room, he quickly acknowledged the pests crawling on the floor. He was directed to the pests on the wall. He stated he was not aware of this as there were no work orders/reports submitted. As the pests began to fly, he stated something needed to be done. He was advised that the resident's call light was not working properly. He stated staff were responsible for reporting things like this. During the interview, Certified Nursing Assistant (CNA) G entered the room. She stated the call light was going off at the nurses' station. She approached the resident asking what he needed and as she went to turn off the call light, she observed the insects crawling on the call light box on the wall and quickly withdrew her hand. She stated she had not seen them before. The Maintenance Director stated the resident needed to be relocated and that he would have to get with nursing management. CNA G stated she was not the assigned CNA for Resident #101; CNA F was assigned to Resident #101 today. An interview was conducted on 3/31/26 at 2:28 PM with CNA F who stated she had been employed at the facility for two years. She confirmed that she had received training in Abuse and Neglect, Resident Rights, and ADL care. She stated she was familiar with Resident #101. He was bed-bound and non-verbal. He pointed and used hand gestures to communicate. She was asked to explain the facility's protocol when pests were observed in a resident's room. She stated that should be reported to Maintenance. When asked if she had observed any pests in Resident #101's room, she replied that she had. She stated she observed gnats in the resident's room on the day of this interview. She said she wiped it up with soap and water and verbally notified Maintenance of her observation. On 3/31/26 at 2:40 PM, Resident #67 was observed lying in bed. The bed was in the lowest position. Two fall mats were resting against the wall next to the resident's bed, and a can of soda was on the floor next to the resident's bed. An over-bed table was observed across the room in a corner. The resident rolled over, raised his head, and motioned toward the can of soda on the floor. He then reached for the soda nearly falling off the bed. Licensed Practical Nurse (LPN) XX was summoned to (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assist the resident and she was accompanied to his room. An interview was conducted with LPN XX on 3/31/26 at 3:04 PM. She stated she was familiar with the resident. When asked how he transferred, she stated she was unsure and would have to check the Kardex. When she was asked whether the resident was at risk for falls, she replied that she was unsure. Her attention was directed to the bed in the lowest position. She stated that was an intervention for residents who were identified as at risk for falls. She stated if the resident was at risk for falls, he would also have had mats down on the floor. Her attention was then directed to the fall mats resting against the wall. She said, Oh. She was asked if/when they should be down. She stated the mats should be down whenever the resident was in bed as long as they were not a hazard to the resident. An interview was conducted on 3/31/26 at 4:35 PM with the Housekeeping Supervisor. She stated she had been working at the facility for five years. She was asked about the facility's housekeeping protocol. She stated housekeeping staff were to clean each room daily and then return to check each room two to three more times each day to ensure the room remained clean. The housekeeping staff were to clean any high-touch surfaces including bedside tables, bed rails, door handles, air conditioning units, windowsills, toilets, sinks, and paper towel dispensers. She explained that there was no checklist for staff to complete once they finished their daily cleaning. She said she inspected the rooms after they had been cleaned, as needed; however, she was unable to confirm how often she did this or provide any evidence that she was rounding to check resident rooms as stated. A tour of the facility was conducted with the Housekeeping Supervisor and the Maintenance Director. They were shown the identified environmental concerns. The Housekeeping Supervisor confirmed that these areas should have been cleaned but stated the insect concerns would have been reported to maintenance rather than housekeeping. The Maintenance Director confirmed that repairs were needed stating he would ensure they were done. A review of the facility's 5-Step Daily Room Cleaning procedure revealed: Empty Trash Collect trash from all rooms as a first priority. Replace liner as needed. Sanitize the trash can daily. Be aware of sharps or other potentially hazardous materials in trash. Horizontal Surfaces - disinfected Using a solution of properly diluted germicide, sanitize all horizontal surfaces (allowing for appropriate solution dwell time). As you enter the room, work clockwise around the room hitting all surfaces. Tabletops, headboards, windowsills, chairs - should all be done. 3. Spot Clean Walls Vertical surfaces are not completely wiped down daily - but must be spot-cleaned daily. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Walls - especially by trash cans, light switches and door handles - will need special attention. 4. Dust Mop The entire floor must be dust mopped - especially behind dressers and beds. Employees should never damp mop a floor before it has been dust mopped. Move all furniture to dust mop. All corners and along all baseboards must be dust mopped to prevent buildup. When water pushes dust into corners, problems occur 5. Damp Mop Remember - The procedure is to damp mop- not wet mop. The most important area of a patient's room to disinfect is the floor. This is where most air-borne bacteria will settle and so it needs to be sanitized daily.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observations, interviews, and record review, the facility failed to provide an environment free from physical restraints for one (Resident #10) of one resident observed in a Geri Chair (reclining chair).The findings include:During an observation on 3/31/26 at 9:45 AM, Resident #10 was observed in a reclining chair (Geri-Chair) in the dining room on the south nursing unit. A review of the resident's medical record revealed no physician's order for a Geri-Chair.A review of the resident's active care plan revealed no care plan addressing the Geri-Chair.During an observation on 4/1/26 at 9:30 AM, Resident #10 was observed sitting in a Geri-Chair in the activity room, watching television.During an observation 4/1/26 at 11:40 AM, Resident #10 was observed sitting in a Geri-Chair in the activity room. The chair was pushed up to a table and the resident was watching television.During an interview on 4/1/26 at 11:00 AM, Certified Nursing Assistant (CNA) J stated She [Resident #10] loves her independence. I'm not sure why she got put in the chair, but it was probably about a month ago to keep her from falling.During an interview on 4/1/26 at 11:30 AM, CNA R stated, I had a weekend off and when I came back, I was told by the nurse that she was to be in the Geri-Chair. She said it was because of her falls. CNA R stated she was unable to recall which nurse gave her this information.During an interview on 4/1/26 at 1:30 PM, Occupational Therapist (OT) S stated, It was just a temporary thing to put her in the chair. I didn't document it. When he was asked more than once to explain why the reclining chair was being used, OT S did not provide a clear response.During an interview on 4/1/26 at 2:30 PM, Physical Therapist (PT) K stated, I don't know who put her in that chair. When asked to explain the clinical rationale for Resident #10 having been placed in a restrictive chair (Geri-Chair), PT K replied, I don't know.During an interview on 4/1/26 at 4:30 PM, PT K stated, I just did a complete re-evaluation on her [Resident #10] and she is okay for a standard wheelchair. When asked where the documentation was for her being placed in the reclining chair (Geri Chair) originally, PT K stated, I do not know where that is.During an interview on 4/2/26 at 11:00 AM, Minimum Data Set Registered Nurse (MDS RN) O stated, I wasn't aware of her being in a Geri-Chair so it wasn't care planned. We hold IDT (interdisciplinary team) reviews after every fall and a Geri-Chair was never mentioned as an intervention.During an interview on 4/2/26 at 9:58 AM, the Director of Clinical Services (DCS) stated, So, when I spoke to them (staff), it appears that when she first came in the regular wheelchair, I believe she couldn't sit up for a long period of time, and that was why they put her in the Geri-Chair. When asked where this was documented, the DCS replied, OT said they did it. When the DCS was advised that this was not documented anywhere in the Occupational Therapy note review, the DCS replied, I don't know where it is.A review of Resident #10's electronic health record revealed an admission date of 1/16/26 and the following pertinent diagnoses: dementia-severe, adult failure to thrive, diabetes mellitus, depression, and repeated falls. There was no physician's order for Resident #10 to be placed in a Geri-Chair. A review of the resident's active Care Plan revealed no interventions for the use of a Geri-Chair.A review of the facility's policy titled Physical Restraints (effective 11/30/14), revealed:Procedure: A restraint evaluation will be performed by nursing to assess physical, mental and other contributing factors which indicate the need for a restraint. The interdisciplinary team may use restraint decision-making tools as needed to assist in determining restraint versus enabler versus restraint/enabler. The resident/responsible party will sign consent for the use of a safety device after review of risks/benefits. The nurse will obtain the physician's orders for the restraint. Restraint use is documented in the resident care plan and in the nurses' notes.

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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 observation, interviews and record review, the facility failed to ensure that residents received adequate supervision and assistance devices to prevent accidents for one (Resident #59) of five residents reviewed for accident hazards from a total survey sample of 21 residents. A staff member was observed transferring a dependent resident using a mechanical lift without the assistance of a second staff member. The resident was observed swinging from side to side in the lift as the staff member attempted to lower the resident onto a shower bed. This action could have resulted in serious harm to the resident.The findings include:On 3/30/26 at 11:15 AM, Resident #59 was observed in the hallway outside of his room. He was hanging from a Hoyer lift (mechanical lift) that was being operated solely by Certified Nursing Assistant (CNA) E. No other staff members were observed in the resident's room or in the hall. CNA E was observed moving Resident #59 into position over a shower bed constructed of PVC pipes and a waterproof mattress. CNA E lowered Resident #59 down toward the shower bed, pausing the Hoyer lift repeatedly during the process as the resident swung from side to side in mid-air. CNA E released a control attached to the Hoyer lift in an attempt to steady the resident and stop the swinging motion. Once the resident's movement was controlled, CNA E resumed operating the lift, unassisted, and lowered Resident #59 onto the shower bed. (Photographic evidence obtained)An interview was conducted on 3/30/26 at 11:21 AM with Licensed Practical Nurse (LPN)/Unit Manager A. She was advised of the observation of CNA E operating the Hoyer lift by herself. Unit Manager A walked hurriedly down the hall where Resident #59's room was located. As Unit Manager A approached the resident's room she observed CNA E as she continued to maneuver the Hoyer lift with Resident #59 suspended in mid-air above the shower bed. She asked CNA E what she was doing and where her help was. CNA E responded inaudibly as she shook her head and shrugged her shoulders. Unit Manager A repeatedly asked the resident if it was his preference to receive care in the hallway. The resident only shook his head and did not respond verbally. Unit Manager A continued, This is your preference to be in the hall, right? Resident #59 did not provide a verbal response.An interview was conducted on 3/30/26 at 11:36 AM with Unit Manager A. She was asked about the observation of CNA E operating the Hoyer lift by herself. Unit Manager A confirmed that CNA E should not have operated the Hoyer lift alone. She stated CNA E should have waited for another staff member to assist her.An interview was conducted on 3/31/26 at 10:15 AM with Resident #59. He was asked about the observation on 3/30/26 of his being transferred with the Hoyer lift operated solely by CNA E. Resident #59 stated he knew two staff members were required to operate the lift. He stated CNA E was unable to find another staff member to assist her and proceeded to operate the lift by herself.On 4/1/26 at 4:02 PM, an interview was conducted with CNA E. When asked about transferring Resident #59 via the Hoyer lift without assistance on 3/30/26, CNA E reported knowing that the Hoyer lift required two staff members to operate, but she could not find a second staff member. CNA E reported wanting to get Resident #59 to the shower, so she decided to transfer the resident without assistance. When asked, CNA E stated it was not normally difficult to find a second staff member to assist with transferring a resident via Hoyer lift.A review of Resident #59's medical record revealed an original admission date of 6/4/25 with his most previous admission on [DATE]. His diagnoses included paraplegia, assault by firearm, colostomy, and dysphagia.A review of the resident's Quarterly Minimum Data Set (MDS) assessment, dated 2/17/26, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 possible points, indicating intact cognition. There were no documented signs of psychosis, behavioral symptoms, or rejection of care. The MDS further revealed that Resident #59 had impairment of lower extremities with documented dependence for toileting and moving from lying to sitting position and substantial to maximum assistance for rolling left and right. Resident #59's active care plan was reviewed and revealed that the resident was (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at risk for skin integrity related to fragile skin. The goal was to ensure that he remained free from complications related to pressure injuries. The interventions included using a draw sheet or lifting device to move the resident and to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. A review of the facility's policy and procedure titled Lifting and Moving Residents (effective 11/30/14), revealed: Procedure: 1. Assess the resident's condition and mobility. (Determine if resident has been designated as a 2 or 4 person lift.) 2. Get help if at all in doubt about your ability to move the resident alone. Use resident transfer equipment as required. (Do not attempt to lift any resident alone that has been designated as a 2 or 4 person lift.)

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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 - Minimal harm or potential for 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** Based on observations, record review, interviews and on a review of the facility's policy titled Oxygen Therapy, the facility failed to ensure that a resident who required 0respiratory care, was provided such care, consistent with professional standards of practice for one (Resident #74) of four residents reviewed for oxygen therapy from a total survey sample of 21 residents.The findings include:On 3/30/26 at 12:44 PM, Resident #74 was observed sitting up in bed with oxygen infusing at a flow rate of 3 liters per minute (LPM) via nasal cannula. (Photographic evidence obtained)On 3/31/26 at 10:48 AM, the resident was observed sitting in the dayroom watching television with oxygen infusing at 3 LPM via nasal cannula. (Photographic evidence obtained) On 3/31/26 at 10:40 AM, a review of the resident's active physician's orders revealed an order for oxygen to be delivered a 2 LPM continuously. The order was written with a start date of 10/5/25.On 3/31/26 at 10:52 AM, Licensed Practical Nurse (LPN) A was observed changing the flow rate setting on the oxygen concentrator from 3 LPM to 2 LPM. When she was asked why she changed the flow rate setting, she stated the oxygen flow rate was set at 3 LPM and it should have been set at 2 LPM according to the current order. She was asked how a nurse knew the appropriate oxygen flow rate a resident was supposed to receive. She stated the nurse should go by whatever the physician ordered. She was asked how often the nurse checked the resident's concentrator to ensure the flow rate setting was correct. She stated, They should check it every shift. LPN A confirmed she had received education for how to care for the resident receiving oxygen therapy. The resident was not observed attempting to change her oxygen flow rate setting during the survey. On 3/31/26 at 2:10 PM further review of Resident #74's medical record revealed an admission date of 10/2/25 and diagnoses including acute respiratory failure with hypoxia and chronic obstructive pulmonary disease (COPD). Progress notes from 12/29/25 through 3/31/26 were reviewed with only one entry regarding a resident-specific behavior of manipulation of the oxygen concentrator. This was documented during the survey after the surveyor observed the oxygen concentrator flow rate at the incorrect setting.A review of the physician's progress note dated 2/6/26 at 5:13 PM revealed a pulmonary follow-up for COPD and hypoxia.A review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a brief interview for mental status (BIMS) score of 14 out of 15 possible points, indicating intact cognition. There was no documented psychosis or behaviors, and she required substantial/maximal assistance with bed mobility and transfers. Shortness of breath with exertion and when lying flat was documented along with the need for oxygen therapy.On 4/1/26 at 3:11 PM, an interview was conducted with CNA T. She was asked to explain her role and responsibility when caring for a resident who received oxygen. She stated her responsibility was to ensure that the nasal cannula was in place in the resident's nose. She stated she was not tasked with adjusting the flow rate setting on a resident's oxygen concentrator, nor had she ever been instructed by a nurse to change the flow rate setting on an oxygen concentrator. On 4/2/26 at 2:33 PM, an interview was conducted with the Director of Nursing (DON). He was asked what his expectations were regarding the care of residents who received oxygen therapy. He stated the facility had an Angel Rounds program that involved all managers who made routine rounds of each resident's room and documented any areas of concern; this included oxygen concentrator settings. He stated, The CNAs (certified nursing assistants) know not to touch or attempt to adjust the concentrators, but we have a system where we tag the concentrator with the number of liters the resident should have. This system allows any staff to be able to observe if the liters are incorrect whenever they encounter the resident and to report to the proper staff so the liters can be adjusted.A review of the facility's policy titled Oxygen Therapy (Document Name: RT-430, effective 11/30/14, revision on 8/28/17), revealed:Start O2 (oxygen) flow rate at the prescribed liter flow or appropriate flow for administration device.