STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105776	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Port Orange Nursing and Rehab Center	5600 Victoria Gardens Blvd Port Orange, FL 32127

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and facility policy and procedure review, the facility failed to ensure that two (Resident #3 and Resident #113) of three residents reviewed for limited range of motion (ROM) received appropriate treatment and services to increase range of motion, and/or to prevent further decrease in range of motion, in a total survey sample of 36 residents. The findings include:1. During the initial tour on 3/29/26 at 1:51 PM, Resident #3 was observed in bed. Her right arm was contracted to the elbow, and her left-hand fingers were also contracted. She did not have any splints on her elbow or hand. When she was asked if she had any concerns, she stated she wanted to have more range of motion. She explained that there was an aide that conducted range of motion (ROM) with her, however, there is no consistency with the care because she keeps being taken away to work on the floor. When there is no consistency, I feel too much pain when they try to do it.Review of the medical record for Resident #3 revealed she was admitted to the facility on [DATE], with a re- entry on 3/15/25. Her diagnoses included atherosclerosis of native arteries of right leg with ulceration of heel and midfoot, quadriplegia, and peripheral vascular diseases. Review of the modified quarterly minimum date set (MDS) with an assessment reference date (ARD) of 1/29/26 indicated the resident had a brief interview for mental status (BIMS) score of 15 out of 15, indicating she was cognitively intact. She exhibited no behaviors and was dependent on staff with bed mobility, transfer and hygiene/grooming.Review of the physician's orders dated 3/30/26, revealed an order for Therapy/Splinting: [NAME] bilateral C-bar splints and right soft elbow splint in the morning after breakfast and doff prior to lunch as tolerated. May be removed for skin integrity checks, hand hygiene, and/or cleaning of splint. (Copy obtained)Additional physician orders included: Apixaban 2.5 mg (milligrams) by mouth two times a day for Prophylaxis 1/20/26. Clopidogrel Bisulfate Tablet 75 mg, give one tablet by mouth one time a day for blood clot prevention 3/16/25. Hydrocodone-Acetaminophen 5-325 mg, give one tablet by mouth every 8 hours for pain hold for sedation 7/7/25.During another observation on 3/30/26 at 10:00 AM, Resident #3 was observed in bed. She did not have any splints on her elbow or hand.Review of the resident's care plan, revised on 2/5/26 indicated that the resident required a Splint/Brace with nursing restorative program to right and left hand. Interventions included bilateral comfy hand splints as ordered/tolerated as she allows and gentle ROM prior to splint application. The care plan also indicated that the resident has an activity of daily living (ADL) self-care performance deficit related impaired functional mobility, limits to ROM to bilateral upper extremities (BUE) and bilateral lower extremities (BLE), age and commodities. She makes the choice not to get out of bed. Interventions included right elbow freedom adjustable splint and bilateral resting hand splints per orders/instructions. 2. On 3/30/26 at 11:24 AM, Resident #113 was observed in her room seated in a wheelchair. Her left wrist was contracted, and she could not open her palm. Her bilateral lower [NAME] appeared swollen, and she did not have compression stocking. When she was asked if the facility assisted with splinting, she nodded yes. When she was asked if she had any brace, she nodded no. Her mom (roommate) spoke up and said that she used to have braces but does not know what happened to them. Review of the medical (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105776	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Port Orange Nursing and Rehab Center	5600 Victoria Gardens Blvd Port Orange, FL 32127

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Clinical record for Resident #113 revealed she was admitted to the facility on [DATE]. Her diagnoses included cerebral palsy, severe intellectual disability, anxiety disorder and major depressive disorder. Review of the quarterly MDS with an ARD of 2/3/26 noted that the resident has a BIMS score of 8 out of 15, indicating moderate cognitive impairment. She required substantial to maximum assistance with upper body dressing and dependent with putting on/taking off footwear.Review of physician's order, dated 1/30/26, read, add compression to BLE due for edema - On in the morning and remove at bedtime for Compression to BLE. Another order dated 3/30/26 revealed therapy/splinting: [NAME] left palm guard in the morning after breakfast and doff prior to lunch or as tolerated. May be removed for skin integrity checks, hand hygiene, and/or cleaning of splint- 3/30/26.During another observation on 3/31/26 at 10:17 AM, Resident #113 was observed in her room fully dressed seated in her wheelchair. She was not wearing any braces or leg compression stockings. Review of the resident's care plan revised 2/24/26 indicated she has impaired cognitive function/impaired thought process r/t severe intellectual disabilities. Resident will be offered to go down to therapy to be with the mom due to behaviors when her mom is not with her. She will be encouraged to participate in diversional activities. Further review of the care plan Revised 6/23/25 indicated that the resident required a passive range of motion with nursing restorative program. Passive ROM - Approach/Precautions and encourage compliance to be completed daily (QD), 7 days a week before and after splinting as she allows. Resident has an ADL self-care performance deficit related to: Cerebral palsy, severe intellectual disabilities, depression and anemia. Intervention included compression (TED) hose per order. Left palm guard per order as she allows.In an interview on 3/31/26 at 11:00 AM, the Regional Clinical Director (RCD) stated that she was informed that the facility did not have restorative nursing program, instead it offered a national maintenance program (FMP) through skilled therapy. She mentioned that the Director of Rehab (DOR) would be providing the list of residents on FMP.On 3/31/26 at 11:15 AM, the RCD provided a list of residents on FMP for ST, PT and OT. There was no indication of the services these residents were receiving under each discipline. When asked if she was aware what services they were receiving. She stated that she would inform the DOR to come and explain. Residents #3 and #113 were not in the list. During a joint interview on 3/31/26 at 12:26 PM, with the DOR and the Regional Rehab Manager, they mentioned that when residents are picked up for part B services the rehab department determined if they need FMP. They added that therapy also does quarterly screens to determine resident's needs and most of the skills are conducted by skilled therapy as the facility did not have restorative nursing program. They explained that some services are added to the Certified Nursing Assistants (CNAs) Kardex for the CNAs to provide care. They confirmed that both Residents #3 and #13 were not on FMP programs.During an interview on 3/31/26 at 2:22 PM, with CNA E/Restorative aide, she reviewed the computer point of care system and printed a list of on restorative nursing program. When asked about Residents #3 and #113, she confirmed that they were on the restorative nursing program. However, she acknowledged that she had not been providing restorative services for the last 7 weeks because she kept being pulled to work on the floor due to lack of staffing coverage.On 3/31/26 at 3:30 PM, CNA E was asked to go to Resident #3 and Resident #113's room. After observing Resident #3, CNA E confirmed the resident did not have any splints on and retrieved them from the resident's drawer. (Photographic evidence obtained) When CNA E observed Resident #113, she confirmed the resident did not have any splints or compression stockings on. CNA E retrieved the splints from the resident's drawer. (Photographic evidence obtained) She confirmed that she had not placed the splints on because today was her first day back as restorative aide and she was tasked to obtain monthly weights. A review of the facility's policy and procedure titled Restorative Nursing program revised 8/2023 revealed the following:PURPOSE: It is the policy of the center to assist each Resident to attain and or maintain their individual highest most practicable functional level of independence and well-being, in accordance to State and Federal Regulations FUNDAMENTAL INFORMATION: It is recognized that there are occasions when residents may have unavoidable declines which may not be reversible which might not be under the control of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105776	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Port Orange Nursing and Rehab Center	5600 Victoria Gardens Blvd Port Orange, FL 32127

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the center. Furthermore, it is recognized that some residents may not wish to participate in restorative care programming will be respected as election of choice and documented accordingly. PROCEDURE: 1. Each resident will be screened and or evaluated by the Nurse designated to oversee the restorative nursing process for inclusion into the appropriate center restorative nursing programs) when it has been identified by 1 interdisciplinary team that the resident is in need or may benefit from such programs). 2. The screening will include the resident or their representative's input, choices, and expectations related to participating in the restorative nursing program. 3. The center restorative nursing program will include but not be limited to the following programs:Hygiene -bathing, dressing, grooming, and oral care,Mobility-transfer and ambulation, including walking, prosthetic and or splint application with or without active and or passive range of motion, bed mobility, Elimination-toileting, bowel and bladder,Dining-eating, including meals and snacks,Communication, including: i. Speech, ii. Language, iii. Other functional communication systems. 4. The above programs will be documented on the center designated restorative care forms/tools in the res electronic medical record.5. Based on clinical evaluation and ongoing consideration residents may be placed in one or more of the above programs at one time. 6. The designated nurse will be responsible for the following:Obtaining orders for the resident's restorative program,Documentation on a monthly basis (at a minimum), andInitiation and updating restorative care plans. 7. Once in an appropriate restorative nursing program, the designated nurse will continue to monitor the reside progress. 8. The designated nurse will evaluate the restorative documentation monthly to determine if there are any changes needed to the existing program and make a monthly progress note, in the resident's electronic medical record related to this evaluation. 9. For active programs, the resident would normally be expected to reflect progress within a four-week period.10. For maintenance programs, the resident would normally be expected to have already reached their highest level of potential and the therefore be supported to maintain their level and if clinically possible [NAME] off further decline. 11. In the event that it is clinically contraindicated for a resident to participate in a restorative care program, the designated nurse will discuss with the physician or extender and if that is medically determined, the physician or extender will provide an order to direct the staff accordingly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105776	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Port Orange Nursing and Rehab Center	5600 Victoria Gardens Blvd Port Orange, FL 32127

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that two (Resident #28 and Resident #43) of three residents, who were reviewed for inability to carry out activities of daily living (ADLs), from a total of 36 residents in the sample, received necessary assistance to maintain good grooming and personal hygiene. The findings include: 1. Review of Resident #28's clinical record revealed she was admitted to the facility on [DATE] with diagnoses that included type 1 diabetes mellitus with diabetic chronic kidney disease, acquired absence of left leg above knee, occlusion and stenosis of bilateral carotid arteries, and major depressive disorder. Review of the Quarterly minimum data Set (MDS) with an assessment reference date (ARD) of 1/24/25, revealed the resident had a brief interview for mental status score (BIMS) of 11 out of 15, indicating moderate cognitive impairment. She required substantial to max assistance for showers. An observation and interview of Resident #28 was conducted on 3/30/26 at 10:57 AM. While lying in her bed, she said her body was itching all over and it had been going on for over a week. She explained that she notified the nurse and was hoping to get some Benadryl or something for itch relief. When asked about the last time she had a shower, she stated that she could not recall. Review of Resident #28's current physician orders revealed the following: Nystatin External Cream 100000 UNIT/GM (Topical)- Apply to Peri area topically every shift for Candidiasis of skin and vagina for 14 Days -3/18/26- 4/1/26. Triamcinolone Acetonide External Cream 0.5 % (Topical)- Apply to left thigh topically every morning and at bedtime for rash 3/30/26. Hydrocortisone External Cream 2.5 % (Hydrocortisone (Topical) Apply to affected areas topically every day and evening shift for rash for 14 Days including R posterior hip, R mid-low back, posterior R leg 12/10/25. Ammonium Lactate External Cream 12 % (Lactic Acid (Ammonium Lactate)-Apply to affected areas topically every day and evening shift for dermatitis for 14 Days including Right posterior hip, right mid-low back, R upper leg 12/10/25. Review of the Advanced Registered Nurse Practitioner (ARNP) notes dated 3/30/26, indicated that the resident was seen sitting up in her bed, alert and oriented to baseline, in no acute distress. She was complaining of left thigh pruritus. Upon examination, scratches were noted on her left thigh from scratching. Triamcinolone 0.1% ointment was initiated to the left thigh every morning and at bedtime for symptomatic relief. Review of the care plan for Resident #28 revised on 8/15/25 revealed that the resident has an Activities of Daily living (ADLs) Self-Care Performance deficit related to impaired functional mobility, history of fracture right femur post-surgical, Left above Knee Amputation (AKA). She Requires Partial/Moderate assistance of one for personal hygiene. (Copy obtained). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105776	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Port Orange Nursing and Rehab Center	5600 Victoria Gardens Blvd Port Orange, FL 32127

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the CNA task 30 days look back from 3/31/26 for Resident #28- indicated that the bathing task did not occur (Copy obtained). On 3/31/26 at 1:58 pm, an interview was conducted with Certified Nursing Assistant (CNA) F who was assigned to Resident #28. When asked how she identified residents' needs, she explained that she reviewed the Kardex, ask the CNA during report, ask nurses and/or therapist. When asked how often residents received a shower. She said, Twice a week, there is shower books at the nurses' station. The showers are splits in two shift days and evening shift. She added that the shower list is sometimes added to the assignment board at the nurse's station. When asked if the showers are documented when provided, she said, Yes, Once the shower is provided it's documented in the computer and the shower sheet that's provided to the nurse. When asked to describe Resident #28, she said she was alert and oriented, and able to make needs known. The resident needed assistance with ADLs and does not refuse care. She confirmed that the resident had a rash mid lower back. When asked if the resident had a recent shower, she stated that she had to review the Kardex because her showers were scheduled in the afternoon. On 3/31/26 at 3:44 PM, an interview was conducted with Licensed Practical Nurse (LPN) G/Unit Manager who was familiar with Resident #28. She stated that the residents received showers at least 2 times a week and if they refuse, they should be offered at a different time or day. She confirmed that showers should be documented in the shower sheet and on the electronic point of care documentation. If the resident refuses a shower the CNAs should also notify the nurse. The Nurse would then attempt to offer a different bath like bed bath, of sponge bath. When asked about Resident #28's care needs, she stated that the resident required moderate assistance with transfer. She can roll in bed, self- propel in wheelchair. She is incontinent of [NAME] and bladder. She explained that the resident was treated for rash recently. She reviewed the ARNP notes dated 3/30/26 and stated that resident had pruritus to thighs and ordered triamcinolone. When asked about the resident's showers days, she confirmed that her shower days were on Wednesday and Saturday in the evening shift. When asked if the resident received the showers, she checked the list for Resident #28 but could not find any documented showers. She checked the paper shower sheets, but she could only find 2 documented showers and one refused shower for the month of March 2026. 2. Review of Resident #43's clinical record revealed she was an [AGE] year old female admitted to the facility on [DATE] with diagnoses that included fracture of unspecified part of neck of left femur, pain in left hip, unspecified abnormalities of gait and mobility, pressure-induced deep tissue damage of sacral region, Alzheimer's disease, and unspecified and muscle weakness (generalized). Review of the Admission/Medicare 5-day MDS dated [DATE] noted the resident had a (BIMS) score of 1 of 15, indicating severe cognitive impairment. The resident's functional status assessment noted a lower extremity impairment on one side, required supervision or touching assistance for personal hygiene, and shower/bathe self-required substantial/maximum assistance. An observation and interview of Resident #43 was conducted on 3/27/26 at 11:25 AM. While lying in her bed, she was observed with coarse facial hair in the chin, jawline, and upper lip area. When asked about the facial hair, she stated, The long facial hair makes her itchy and staff have not offered to help trim or shave her facial hair. On 3/31/26 at 2:16 PM, an interview was conducted with CNA B who was assigned to Resident #43. When asked about Resident #43's facial hair, she stated that she was not aware that the resident had (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105776	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Port Orange Nursing and Rehab Center	5600 Victoria Gardens Blvd Port Orange, FL 32127

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	long facial hair. She said that she received training for activities of daily living (ADL) care during orientation and knows how to provide ADL care from her many years as a CNA. She further explained that if she noticed a female resident with facial hair on the chin, jawline or upper lip area, she would ask the resident if they would like her to clean up the facial hair. She explained that CNAs are expected to notice long facial hair, they must document it on the resident's shower's shower sheet and in the resident's electronic record in Point Click Care (PCC). On 3/31/26 at 2:24 PM, CNA B observed Resident #43 in her room. After looking at the resident, she said, The resident's facial hair is too long. Review of Resident #43's care plan revealed a focus of ADL self-care performance deficit, with a goal noting attempts for the resident to improve current level of function will be provided through the review date. Interventions included: bathing with substantial assistance and personal hygiene with touch or supervision assistance. There was no documented evidence that the resident refused ADL care. Review of the shower schedule for Resident #43 revealed that the resident was to receive showers on Tuesdays and Fridays during the 3-11 shift. Review of shower sheets for the previous three weeks lacked a shower sheet for Resident #43. Review of the resident's electronic medical record revealed the resident received a shower on the following dates and times: 3/17/26 at 22:31, 3/18/26 at 18:18; 3/20/26 at 17:31 and 3/31/26 at 19:15. Review of the facility's document titled Procedural Guidelines, SHCEDU0001.10B, Updated: 09/2023 and Effective: 01/2023 documented: Purpose: To facilitate residents' overall comfort, cleanliness, grooming, and well-being. Documentation Guidance: In care plan document interventions and approaches, and the amount of assistance the resident needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105776	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Port Orange Nursing and Rehab Center	5600 Victoria Gardens Blvd Port Orange, FL 32127

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, interviews, record reviews, and facility policy and procedure review, the facility failed to ensure that one (Resident #131) of two residents reviewed for oxygen therapy, received the correct number of liters of oxygen ordered by the physician, in a total sample of 36 residents. This could result in the resident not receiving appropriate care and/or clinical complications. The findings include:On 3/29/26 at 11:13 AM, Resident #131 was observed lying in bed with oxygen (O2) via nasal canula (NC). An observation of her oxygen concentrator revealed the oxygen flow was set at 1.5 liters per minute (LPM). (Photographic evidence obtained) When the resident was asked if she adjusted the flow of the oxygen concentrator, she replied, No, I don't touch it. Review of the medical record for Resident #131, revealed she is an [AGE] year-old female admitted to the facility on [DATE], with diagnoses including congestive heart failure, dependence on supplemental oxygen, unspecified asthma, uncomplicated, acute respiratory failure with hypoxia, and shortness of breath. A review of the physician's order written on 3/22/26 revealed, O2 via NC at 2 LPM. Review of Resident #131's admission /Medicare - five-day minimum data set (MDS) assessment, dated 03/27/26, revealed the resident had a brief interview for mental status (BIMS) score of 11 out of 15, indicating moderate cognitive impairment. The resident receives oxygen therapy.On 3/31/26 at 10:00 AM, Resident #131 was observed lying in bed with oxygen via NC. An observation of her O2 concentrator revealed the oxygen flow rate was set at 1.5 LPM. (Photographic evidence obtained)Review of Resident #131's care plan created on 03/22/2026, noted she has O2 therapy related to congestive heart failure. The goal indicated a risk of signs and symptoms of poor oxygen absorption will be minimized through the review date. No interventions were documented. On 3/31/26 at 1:53 PM, Licensed Practical Nurse (LPN) D entered Resident #131's room. She bent down to eye level of the O2 concentrator flow rate and confirmed the flow rate was set at 1.5 LPM. On 3/31/26 at 1:56 PM, LPN D reviewed Resident #131's medical record in Point Click Care (PCC) and reported the resident's O2 order is written for 2 LPM. She reviewed the medication administration record (MAR) and stated that she documented 2 LPM for the resident at 10:19 AM this morning. LPN D was asked to explain her process to ensure residents on O2 therapy receive the correct amount. She stated that she reviews O2 orders and then checks concentrator flow rates to ensure they match. She explained that she checks O2 concentrator rates throughout her shift. Review off the facility's Oxygen Administration policy, Revised: 08/2023, disclosed .Procedure 1. Check physician's order.11. Turn the unit on to the desired flow rate and assess equipment for proper functioning.