STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105963	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lafayette Nursing and Rehabilitation Center	512 W Main St Mayo, FL 32066

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to encode and transmit the resident discharge assessment for 1 (Resident #1) of 6 residents reviewed for minimum data set [MDS] completion. Findings include:Review of Resident #1's physicians order dated 3/19/2026 read, [Resident #1's name] will discharge to [Facility's Name] in [Town's and State Name] on 3/19/26.Review of Resident #1's Discharge summary dated [DATE] read, Transferring to [Name of Facility]. Mode of Transportation: Transportation provided by facility. Date: 3/19/2026. Time: 11:00.Review of Resident #1's progress note dated 3/20/2026 read, [Resident #1's name] discharged to [Name of Facility] 3/19/2026 in [Town's and State's Name]. [Resident #1's name] is to follow up with PCP [primary care provider] at [Facility's name].Review of Resident #1's Minimum Data Set did not document a discharge assessment. During an interview on 4/8/2026 at 3:20 PM, Staff E, Minimum Date Set Coordinator, Registered Nurse, stated, I verified with my regional and I am missing the discharge assessment which is due 14 days after the resident is discharged and is considered late. Normally I combine the different assessments. I did not do the discharge assessment.Review of the facility policy and procedure titled MDS 3.0 Completion with a last review date of 12/30/2025 read, Policy: Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan. Policy Explanation and Compliance Guidelines: f. Discharge Assessment- completed using the discharge date as the ARD [Assessment Reference Date]. Must be completed with 14 days of the discharge date /ARD.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's active diagnoses for 1 (Resident #20) of 6 residents reviewed for weight and nutrition, by failing to code a thyroid disorder in Section I, resulting in inaccurate clinical data used for care planning, quality measures, and reimbursement. Findings include:Review of Resident #20's active medical diagnosis include thyrotoxicosis, also known as hyperthyroidism.Review of Resident #20's physician's order dated 1/25/2025 read, Methimazole tablet 10 milligrams (MG), give one tablet by mouth one time a day for hyperthyroidism.Review of Resident #20's Annual MDS dated [DATE] section I, subsection I3400 Thyroid disorder was coded as No.During an interview on 4/8/2026 at 1:16 PM, the Regional MDS Nurse stated, I reviewed the MDS concerns and identified that the resident was coded incorrectly in section I for not being documented for having the active diagnosis of thyroid disease.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide care and services to ensure acceptable parameters of nutritional status for 2 (Resident #31 and Resident #61) of 6 residents reviewed for nutritional concerns.Findings include: 1.) Review of Resident #61's clinical record under Vital Signs documented the following weights: 4/1/2026: 122.3 lbs (pounds); 3/25/2026: 122.7 lbs; 3/22/2026: 124.9 lbs; 3/11/2026: 127.3 lbs; 3/8/2026: 133.9 lbs; 3/7/2026: 134.3 lbs; 3/6/2026: 133.2 lbs; 3/5/2026: 133.9 lbs. On 3/05/2026, Resident #61 weighed 133.9 lbs and on 4/01/2026, Resident #61 weighed 122.3 lbs which calculated to a -8.66% Loss. Review of Resident #61's Nutritional Risk Screen assessment dated [DATE] read, 80YOF ([AGE] year-old female) admitted with dx (diagnosis) of fx (fracture), CVA (Cerebrovascular Accident), dysphagia [difficulty with swallowing], T2DM (Type 2 Diabetes Mellitus), hypothyroidism, HTN (Hypertension). Allergy: food dye. Ht (height) 64in, wt (weight) 122.7#, BMI (Body Mass Index) 21.1. Wt trending down since admitted , triggers for -8.4% (-11.2#(pounds)) in 2 weeks. Wt loss possibly r/t (related to) poor PO (by mouth) intake. WNL (within normal limits) BMI. Diet is regular, pureed texture, honey thick consistency. PO intake 0-25%, varies. Independent with meals. Supplement: magic cup QD (every day). Skin intact. Recommendation start fortified food w/meals (with meals) r/t poor PO intake. Monitor and evaluate PRN (as needed). Review of Resident #61's Progress Notes revealed a Dietary note dated 3/13/2026 that read, Ht 64in, wt 127.3#, BMI 21.8. Triggers for wt loss of -5.2% (-7#) in 4 days. Res (resident) in need of additional kcal (kilocalorie, the standard unit used in medicine and nutrition to measure food energy) r/t wt loss and poor PO intake. Recommendation magic cup (a fortified, high-calorie, and high-protein nutritional frozen dessert) daily for additional nutrition support. Monitor and evaluate PRN. Review of Resident #61's Progress Notes from 3/05/2026 through 4/07/2026 revealed there were no notes regarding communication with her physician regarding her weight loss or the recommendations from the RD. Review of Resident #61's Physician Orders revealed an order dated 3/05/2026 that read, Regular diet - Pureed texture, Honey Thick Liquids consistency, for Diet. Review of Resident #61's Physician Orders revealed an order dated 3/13/2026 that read, Magic Cup one time a day for Risk for malnutrition. Review of Resident #61's Care Plan documented a focus for compromised nutrition and hydration status secondary to: variable/poor PO intake, dx of fx, CVA, dysphagia, T2DM, hypothyroidism, HTN, Allergy: food dye with a goal the resident will not have significant weight changes through next review; The resident will maintain weight within ideal body weight range through next review; The resident will maintain adequate nutritional status through review date. Interventions included - Monitor/record/report to MD (medical doctor) PRN s/sx (signs and symptoms) of malnutrition; Refer to RD (Registered Dietitian) to evaluate and make diet change recommendations as needed/PRN. Review of Resident #61's meal tray tickets for 4/08/2026 documented her diet as Pureed, Honey (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Thick Liquid, with an allergy of Food Dye. During an interview on 4/08/2026 at 12:00 PM, Staff A, LPN, Unit Manager stated that the process for monitoring weight loss for the residents was to let the physician know when there was a 5-pound loss. The physician would decide whether to consult the dietitian or start appetite stimulants such as Remeron or Megace. They would contact the dietitian, and the dietitian would do her thing. During an interview on 4/08/2026 at 1:20 PM. the CDM (Certified Dietary Manager) stated that [Resident #61's Name] was not receiving fortified foods. The process was when the dietitian saw a resident, she would email the nurses any recommendations and the nurses would put in the diet orders or modifications. During an interview on 4/08/2026 at 3:30 PM, the RD stated that she made a recommendation for [Resident #61's Name] to have fortified foods because she continued to lose weight. The RD confirmed that [Resident #61's Name] diet order was not changed to add fortified foods; it would show up under the diet [order]. During an interview on 4/08/2026 at 4:43 PM, Staff A, LPN, Unit Manager stated that she had not received any recent emails regarding RD recommendations. She had not received any emails directly from the RD, the DON would forward the RD recommendations to her. No emails had been sent to her today regarding RD recommendations. During an interview on 4/08/2026 at 5:06 PM, the CDM stated that if [Resident #61's Name] were on fortified foods it would show on her meal ticket. He confirmed that not everything they served could be considered fortified. Since [Resident #61's Name] was on a pureed diet, they would add the fortification to whatever food she was having for that meal. Review of the policy and procedure titled Nutritional Management, with the last review date 12/30/2025, read, Policy: The facility provides care and services to each resident to ensure the resident maintains acceptable parameters of nutritional status in the context of his or her overall condition. Compliance Guidelines: 1. A systematic approach is used to optimize each resident's nutritional status: c. Developing and consistently implementing pertinent approaches. 3. Evaluation/analysis: a. The assessment shall clarify the resident's current nutritional status and individual risk factors for altered nutrition/hydration. 5. Monitoring/revision: a. Monitoring of the residence condition and care plan interventions will occur on an ongoing basis. Examples of monitoring include: i. Interviewing the resident and/or resident representative to determine if their personal goals and preferences are being met. Ii. Directly observing the resident. d. The physician will be notified of: ii. Lack of improvement toward goals. 2.) Review of Resident #31's weight on 02/25/2026, the resident weighed 138 pounds. On 03/22/2026, the resident weighed 128.6 pounds which is a -6.81% Loss. Review of Resident #31's dietary note dated 3/27/2026 read, Ht [height] 64in [inches], wt [weight] 128.6# (pounds), BMI 22.1. Triggers for sig [significant] wt loss of -6.8% (-9.4#) in 30 days. Wt continue to trend down, wt loss r/t [related to] variable PO [by mouth] intake. Diet: Regular, mechanical soft with chopped meats texture, thin consistency. PO intake varies 0-100%, some meal refusals. Supplement: med pass 90ml [milliliters] QD [every day], house nutritional supplement 120ml BID [twice a day]. Res [Resident] in need of continued supplement r/t wt loss. Recommendation increase medpass 90ml BID, weekly wt x [times] 4. Monitor and evaluate PRN [as (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed]. Review of Resident #31's physician's order dated 3/13/2026 read, Med Pass one time a day for risk of malnutrition r/t poor PO intake offer 90ml. During an interview on 4/8/2026 at 8:38 AM, Staff C, Licensed Practical Nurse, stated, [Resident #31's name] med pass is once a day. [Resident #31's name] will refuse at times but when you circle back and attempt again, he will drink them. During an interview on 4/8/2026 at 3:30 PM with the Registered Dietitian stated, All recommendations are to be given to the Director of Nursing. At the beginning I would put in my orders into the system and the facility said not to do that and to send an email. This week we had a problem about sending the recommendations to the Director of Nursing because she was not in the facility. This was told to me today in the morning. I am not too familiar with [Resident #31's name] but I addressed his weight loss on 3/27/2026 and 3/13/2026. He [Resident #31] is not eating so great. On 3/13/2026 I added med pass once a day, the increased to twice a day. The same thing happened with this resident, the email did not go to through to the right person and I had to resend a copy today. The med pass was not increased to twice a day. Normally the Director of Nursing does not reply when I send her the emails. During an interview on 4/8/2026 at 4:21 PM, the [NAME] President of Operations stated, The Director of Nursing has been out for about two weeks for a scheduled surgery. We added [Staff A ,Unit Manager, Licensed Practical Nurse's name] to receive the recommendations via email from the Registered Dietitian. I was not aware the Registered Dietitian had made recommendations on 3/27 [3/27/2026]. The process is to send an email with recommendations not just put them in a note. During an interview on 4/8/2026 at 4:41 PM, Staff A , Unit Manager, Licensed Practical Nurse, stated, I was not aware of [Resident #31's name] dietary recommendation. The Director of nursing did not talk to me about how the recommendations would be taken care off when she was out. Normally, she [Director of Nursing] will forward me all the recommendations, and I have not received any new recommendations.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide appropriate milliliter per hour of auto flushes via feeding tube for 1 (Resident #8) of 2 reviewed for enteral feedings.Findings include: During an observation on 4/8/2026 at 1:30 PM with Staff C, Licensed Practical Nurse (LPN), confirmed Resident #8's automatic water flushes were running at 50 ml [milliliters] per hour. During an interview on 4/8/2026 at 1:38 PM, Staff C, LPN, stated, [Resident #8's name] auto flushes should be running at 60 ml per hour. The night shift nurse is the one to hang the feedings. I will need to go back and adjust the flushes. During an observation on 4/8/2026 at 1:43 PM with Staff D, Unit Manager LPN confirmed Resident #8's auto water flushes were running at 50 ml per hour. Review of Resident #8's physician's order dated 2/16/2026 read, Osmolite 1.5 give @ 65 ml/hr [at 65 milliliters per hour] and flush rate of 60 ml/hr via g-tube [gastric] x [times] 20 hrs, one time a day for Nutrition up x 20 hours /down x 4 hours and remove per schedule and remove per schedule. Review of Resident #8's Nutritional Risk Screen and assessment dated [DATE], read, 9. Nutrition Summary: Recommend increase flushes to 60 ml/hr while infusing. Review of Resident #8's progress note dated 3/31/2026, read, EN [enteral nutrition] osmolite 1.5 @ 65ml/hr x 20 hours (1950 kcal [kilocalorie], 81g pro [protein], 993 ml h20 [water]), flush 60 ml water x 20 hours (1200ml h20). During an interview on 4/8/2026 at 3:53 PM, the Registered Dietitian stated, [Resident #8's name] flushes were increased to 60 ml. That would be nursing's function to make sure the flushes are running at the correct ordered rate. During interview an 4/9/2026 at 8:42 AM, the [NAME] President of Operations stated, Nurses are expected to check the flush rate when they are given medications or hanging a new feed. They are to double check rate is correct. Review of the facility policy and procedure titled, Nutrition and Care for Feeding Tubes with a last review date 12/30/2025, read, Policy: It is the policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to extent possible. Policy Explanation and Compliance Guidelines: e. Ensuring that the administration of enteral nutrition is consistent with and follows the practitioner's orders.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, record review the facility failed to document accurately skin assessments for 1 (Resident #56) of 3 residents reviewed for skin conditions.Findings include:During an observation on 4/06/2026 at 10:23 AM, Resident #56 was sitting up in bed. Resident #56's right forearm had a small 2x2 white dressing. The dressing had no date. During an interview on 4/06/2026 at 10:23 AM, Resident #56 stated, On Saturday I bumped myself and got a skin tear. The nurse insisted on putting a dressing on it. Normally, if I was home I would just put Neosporin and that's all. They change the dressing every day. During an observation on 4/7/2026 at 12:10 PM, Resident #56 was sitting up in bed. There was a dressing on his right forearm dated 4/6/2026.Review of Resident #56's physician's orders documented no orders for a skin tear on right arm.Review of Resident #56's progress notes did not document any incident regarding right arm skin tear or provider documentation.Review of Resident #56's medical records did not document a skin assessment for the right arm skin tear.During an interview on 4/7/2026 at 12:13 PM, Staff C, License Practical Nurse (LPN), stated, I am not aware of anything on his right arm. I worked with him last week and he did not have anything on his right arm.During an observation on 4/7/2026 at 12:18 PM, the Staff D, LPN, Unit Manager entered Resident #56's room and asked the resident what had happened to his arm. Resident #56 stated that on Saturday he bumped his arm with the walker and got a skin tear.During an interview on 4/7/2026 at 12:18 PM, Staff D, LPN, Unit Manager, stated Usually for something like that [skin tear], we would need orders in place.During an interview on 4/8/2026 at 10:05 AM, the [NAME] President of Operations stated, The nurse should put a note in the system just so we do not have to wonder and know where the skin tear came from.During an interview on 4/9/2026 at 10:02 AM, Medical Doctor #1 stated, The nurse called me over the weekend in regards to the [Resident #56's name] skin tear. Orders were to cover it if bleeding.Review of the facility policy and procedure titled, Documentation in Medical Record, with a last review date 12/30/2025 read, Policy: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation.Review of the facility policy and procedure titled, Skin Integrity-Skin Tears, with a last review date 12/30/2025 read, Policy: It is the policy of this facility to provide treatment and care to maintain skin integrity. This policy pertains to the prevention and management of skin tears. Policy Explanation and Compliance Guidelines: a. Licensed nurses will conduct a skin assessment in accordance with facility policy.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to follow infection control standards for 1 (Resident #8) of 3 residents reviewed for enhance barrier precautions, failed to perform hand hygiene for 1 (Resident #6) of 2 residents reviewed for enteral nutrition, and failed to provide weekly changes for nebulizer equipment for 1 (Resident #48) of 3 residents reviewed for respiratory services. Findings include: 1) During an observation on 04/08/2026 at 1:30 PM, Staff C, Licensed Practical Nurse (LPN) prepared medication for Resident #8. Staff C entered Resident #8's room and performed hand hygiene. Staff donned gloves but did not don a gown. Staff C checked Resident #8's gastric tube placement and administered Resident #8's medication enterally. During an interview on 4/8/2026 at 1:38 PM, Staff C, LPN, stated, [Resident #8's name] is on enhanced barrier precautions, I should have donned a gown. Review of Resident #8's physician's orders dated 1/8/2026, read, Enhanced Barrier Precautions for high contact residents care activities. Indication: Indwelling medical device every shift for Precautions. During an interview on 4/8/2026 at 3:05 PM, the Infection Preventionist stated, Staff need to wear gloves and gown when the resident is on enhanced barrier precautions and follow the guidelines. During an interview on 4/9/2026 at 8:41 AM, the [NAME] President of Operations stated, Staff are to wear gloves and gown when providing care to residents on enhanced barrier precautions. Review of the facility policy and procedure titled, Enhanced Barrier Precautions Policy, with a last review date 12/30/2025 read, Policy: It is the policy of this facility to implement enhanced barrier precautions for prevention of transmission of multidrug-resistant organisms. Definitions: Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organism that employs targeted gown and gloves use during high contact resident care activities. Policy Explanation and Compliance Guidelines: 4. High-contact resident care activities include: g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes. 2) During an observation on 4/08/2026 at 3:00 PM, Staff B, RN, prior to flushing the G-tube in anticipation of resuming her enteral feeding, the RN donned gloves and a gown. While pulling a gown out of the holder, a gown fell on the floor. The RN picked the gown up off of the floor and returned the gown to the holder. She did not remove her gloves or perform hand hygiene after picking up the gown. She later pulled the gown out of the holder and set it on the resident's bed and instructed the CNA to utilize the gown [and gloves] while assisting Resident #6 with her shower. During an interview on 4/08/2026 at 3:00 PM, Staff B, RN, confirmed that she had picked up a gown off of the floor, set it on the resident's bed, and instructed the CNA to use the gown while providing care to Resident #6. The gown should not have been returned to the holder or used; it should have been discarded. Staff B, RN, also confirmed she did not remove her Personal Protective Equipment (PPE), perform hand hygiene, or don clean PPE after she picked up the gown off of the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/08/2026 at 3:15 PM, the IP (Infection Preventionist) stated that if a nurse was anticipating the need to provide care to a resident with a feeding tube, the nurse should wear a gown and gloves. If a nurse picked up something from the floor [an isolation gown], it should not be returned to the rack, placed on the resident's bed, or used by anyone. The nurse should remove the PPE (personal protective equipment), perform hand hygiene, and don clean gloves and a clean gown before providing care to the resident. Review of Resident #6's admission record revealed she was admitted on [DATE] with medical diagnoses that included cerebral infarction, dysphagia, and gastrostomy status. Review of Resident #6's physician's order dated 1/28/2026, read, Enhanced Barrier Precautions for high contact resident care activities. Indication: indwelling medical device every shift for Precautions. Review of the policy and procedure titled, Hand Hygiene, last reviewed on 12/30/2025 read, Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Policy explanation and compliance guidelines: 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. 6. Additional considerations: a) The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Hand Hygiene Table - Condition: After handling contaminated objects; Before performing resident care procedures. 3) During an observation on 4/06/2026, Resident #48's nebulizer was on her bedside table. The mask and tubing were in a zippered plastic bag dated 3/25/2026. (photographic evidence obtained) During an interview on 4/06/2026 at 2:00 PM, Resident #48 stated that she routinely received nebulizer treatments. During an observation on 4/08/2026 at 12:10 PM, there was a nebulizer on the bedside table for Resident #48. The nebulizer mask and tubing were in a zippered plastic bag with 3/25/26. (photographic evidence obtained) During an interview on 4/08/2026 at 12:00 Staff A, LPN, Unit Manager, stated that the process for oxygen/nebulizer accessories and supplies, such as masks and tubing, was that they were changed every Wednesday, put into a Ziploc bag, and the resident's name, room number and the date were written on the bag. During an interview on 4/08/2026 at 12:30 PM the VP (Vice President) of Operations stated that the expectation was for the oxygen/nebulizer tubing and related respiratory accessories or supplies, were changed every Wednesday and placed in a plastic bag. The bag was labeled, either through writing on the bag or using a sticker, with the resident's name, and the date. Review of Resident #48's admission record revealed she was admitted on [DATE] with medical diagnoses that included chronic obstructive pulmonary disease, asthma, and uncomplicated personal history of other malignant neoplasm of bronchus and lung. Review of Resident #48's physician orders dated 3/30/2026 read, Ipratropium-Albuterol Inhalation (continued on next page)

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Lafayette Nursing and Rehabilitation Center	512 W Main St Mayo, FL 32066

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Solution 0.5-2.5 (3)mg (milligrams)/3 ml (milliliters) (Ipratropium-Albuterol): 1 vial inhale orally two times a day for COPD (chronic obstructive pulmonary disease). Review of the policy and procedure titled, Oxygen Administration, with the last review date 12/30/2025 read, Policy: Oxygen it is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Policy explanation and compliance guidelines: 5. Staff shall utilize standard precautions when administering oxygen or when in contact with oxygen equipment other infection control measures include: d. If applicable, change nebulizer tubing and delivery devices weekly or as needed if they become soiled or contaminated.