STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115040	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center for Advanced Rehab at Parkside, The	110 Park City Road Rossville, GA 30741

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, record review, a review of the facility's policies titled Medication Administration and Pain Management, and a review of the the facility's Standing Orders, the facility failed to ensure nursing staff provided appropriate pain management during care for one of six sampled residents (R) (R66) with suprapubic catheters reviewed for catheter care related to adhereing to the physician orders and ensureing safe medication administration practice. Harm was identified to have occurred on [DATE], when resident (R) 66 experienced unrelieved acute pain during suprapubic catheter care and received a medication without a valid physician order and at an incorrect dose, resulting in ineffective pain control. Findings included:During an observation on [DATE] at 11:02 am, Licensed Practical Nurse (LPN) CC was observed providing suprapubic catheter care for R66. R66 was lying in bed receiving oxygen therapy when the nurse initiated care. LPN CC first cleansed the suprapubic catheter insertion site using gauze with a soapy solution, followed by gauze with warm water, in repeated strokes. With each cleansing stroke, R66 immediately cried out in pain, stating, Ouch, that hurts. A visible amount of blood was observed on the gauze with each stroke, coinciding with the resident's expressions of pain. The resident turned away from the nurse, pulled his body inward, and guarded his lower abdomen. Despite these responses, the nurse continued the procedure and repeatedly attempted to reposition the resident toward her to continue care. The nurse acknowledged the resident's pain by stating, I know, I'm almost done, but did not stop the procedure or assess the resident's pain.The resident's pain responses occurred consistently with each cleansing stroke and manipulation of the catheter site. With each contact, the resident vocalized pain and attempted to protect the area by withdrawing and curling his body. As the nurse proceeded to manipulate and cleanse the catheter tubing, which occurred as the final step of the procedure, including pulling on the tubing, the resident cried out loudly and exhibited increased signs of distress, further guarding the area.At that time, the surveyor asked the resident if the procedure was painful, during manipulation of the catheter tubing, and the resident responded yes while continuing to vocalize pain. When asked if this level of pain was typical, the nurse stated, he does cry out in pain during care, indicating this occurs with catheter care, which is ordered to be performed daily. When asked about the frequency of pain management, the nurse stated the resident is medicated for pain maybe once a week, despite daily catheter care. When asked about the presence of bleeding at the site, the nurse stated, Yes, it bleeds sometimes.Only after the nurse completed the procedure did the nurse ask the resident if he wanted something for pain. The resident responded, Yes, I'm hurting. The nurse then left the room to obtain medication without performing a pain assessment, including no use of a pain scale or assessment of location, severity, or characteristics of pain. The nurse returned and administered an acetaminophen 325 mg (milligram) tablet, two tablets (650 mg total).A review of the facility's Standing Orders revealed that LPN CC failed to follow the current standing order instructions, did not enter the order into the Medication Administration Record (MAR), and administered an incorrect dose. As a result, the medication was administered without a verified active order and not in accordance with the current physician orders, as follows:A standing order dated [DATE] authorized 1. Tylenol 650 mg (by mouth) (every six hours) for (temperature) greater than 100 (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 0684 Level of Harm - Actual harm Residents Affected - Few	F (degrees Fahrenheit). This was identified as an older, obsolete standing order and was no longer the current directive for administration. A more current standing order was later provided to the surveyor for review.A more recent standing order dated [DATE] authorized Tylenol Extra Strength two tablets by mouth (every six hours) (as needed) (pain or fever). Further review of the order included instructions TO ENTER-Go to Orders-select BATCH UPDATE, in the drop-down menu select ADD ORDER SET, then select CONGESTION/COUGH STANDING ORDER and edit as needed.During an interview on [DATE] at 11:23 am, LPN CC confirmed that she did not stop the procedure to assess the resident's pain, did not utilize a pain scale, and did not complete a formal pain assessment during care. The nurse stated she proceeded with care by cleaning easier and completing the task quickly while informing the resident she was almost finished. The nurse further stated she was unable to determine the cause of the resident's pain and indicated that appropriate pain assessment should include speaking with the resident and asking what can be done to help, as well as assessing how the pain feels, where it is located, and what it feels like; however, these assessments were not performed during the procedure. The nurse also stated that pain assessments should be documented in the progress notes, but were not completed at that time. The nurse confirmed that any medication order should have been entered into the MAR before administration. The nurse further confirmed that the standing orders referenced were intended for fever management and not for pain control.A review of the electronic medical record (EMR) revealed R66 was admitted on [DATE] and pertinent diagnoses, including but not limited to obstructive and reflux uropathy with the presence of a urogenital implant/suprapubic catheter, recurrent urinary tract infections, chronic kidney disease, and acute kidney injury.A review of R66 Medicare 5-day Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of seven, indicating severe cognitive impairment. Section GG, functional status, indicated impairment in both lower extremities with substantial to maximal assistance required for activities of daily living (ADLs). Section H, bowel and bladder, indicated an indwelling urinary catheter, with the resident always being incontinent. Section I revealed diagnoses including renal insufficiency, renal failure, end-stage renal disease (ESRD), obstructive uropathy, and a urinary tract infection within the past 30 days.A review of R66 care plan dated [DATE] indicated a problem of suprapubic catheter care with risk for urinary tract infection and pain management needs. Goals included but were not limited to prevention of signs and symptoms of infection and the resident verbalizing adequate pain relief. Interventions included but were not limited to providing catheter care each shift, maintaining catheter site hygiene, securing tubing, monitoring and documenting urinary output, observing and reporting signs and symptoms of infection, assessing pain each shift, administering pain medications as ordered, providing non-pharmacological pain interventions, and notifying the physician of ineffective pain management or changes in condition.A review of the Physician's Orders for R66 included, but was not limited to: Order dated [DATE] at 11:46 am for Acetaminophen (Tylenol) Tablet 325 mg, give two tablets by mouth every six hours as needed for pain or elevated temp greater than 101 F (order entered into the MAR following administration). Order dated [DATE] for Change suprapubic catheter (20 Fr 30 mL) monthly and (as needed) for malfunction. Order dated [DATE] for Clean suprapubic catheter site every shift and apply split gauze. Order dated [DATE] for Supra pubic catheter care every shift with dressing application. Order dated [DATE] for Monitor output of catheter and document every shift. Order dated [DATE] for Supra pubic catheter connected to bedside drainage every shift. Order dated [DATE] for assessing the resident for pain every shift. Order dated [DATE] for Clean suprapubic catheter site with warm soap and water or wound spray every shift. Order dated [DATE] for Enhanced Barrier Precautions for catheter/ESBL history/wound.A review of R66's progress notes dated [DATE] at 11:30 am revealed an order for acetaminophen 325 mg tablet, give two tablets by mouth every six hours as needed for pain or temperature greater than 101 F was entered following administration. Progress note dated [DATE] at 12:09 pm revealed nursing contacted the physician to obtain an order for acetaminophen for reported pain and tenderness during suprapubic catheter care, (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	and the order was obtained after the medication had already been administered.During an interview on [DATE] at 12:19 pm, the Director of Nursing (DON) revealed that, per facility expectations for pain assessment and management during treatments such as catheter or wound care, nursing staff are expected to stop the procedure when a resident expresses pain, assess the resident, and determine appropriate interventions or medications. The DON stated that nurses should assess pain during care, including observing for verbal and nonverbal indicators and, when able, asking the resident to rate pain on a scale of 1 to 10. The DON further stated that pain assessments should occur before, during, and after procedures as part of standard nursing practice. When asked about the observed incident, the DON confirmed she was aware of the situation and stated she would expect the nurse to stop the procedure, assess the resident's pain, and review the MAR and any applicable orders prior to proceeding. The DON indicated she was not fully familiar with standing orders but acknowledged that appropriate verification of orders should occur before medication administration. When asked about determining harm, the DON stated that pain should always be assessed and confirmed that this situation would trigger an internal review and investigation, which was in progress at the time of the interview. The DON reported concerns under investigation, including that the nurse administered medication without first ensuring it was properly entered into the MAR and may have administered an incorrect medication based on standing orders. The DON further reported that a wound care nurse would be consulted for additional assessment of the resident.Follow-up interview with the DON revealed that R66 previously had pain medication orders, which had dropped off the MAR following a recent hospitalization.A review of the facility policy titled Pain Management, revised [DATE], revealed, The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Review of the section Recognition revealed item 1. In order to help a resident attain or maintain his/her highest practical level of physical, mental, and psychosocial well-being and to prevent or manage pain, the facility will: a. Recognize when the resident is experiencing pain and identify circumstances when the pain can be anticipated. b. Evaluate the resident for pain and the cause(s). c. Manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences. Item 3. Facility staff will be aware of verbal descriptors a resident may use to report or describe their pain. Further review of section Pain Assessment item 1. The facility will use a pain assessment tool, which is appropriate for the resident's cognitive status, to assist staff in consistent assessment of a resident's pain. Section Pain Management and Treatment item 1. Based upon the evaluation, the facility, in collaboration with the attending physician/prescriber, other health care professionals, and the resident and/or the resident's representative, will develop, implement, monitor, and revise as necessary interventions to prevent or manage each individual resident's pain beginning at admission.A review of the facility policy titled Medication Administration dated [DATE] revealed, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice. Further review of item 10. Review MAR to identify medication to be administered. Item 12. Identify expiration date. If expired, notify nurse manager. Item 14. Administer medication as ordered in accordance with the manufacturer's specifications. Item 17. Sign MAR after administered. Item 20. Correct any discrepancies and report to the nurse manager.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, staff interviews, and review of the facility policy titled Physical Environment: Electrical Equipment, the facility failed to ensure the environment was maintained in a safe, sanitary, and functional condition in three of 15 rooms (Rooms 134, room [ROOM NUMBER], and room [ROOM NUMBER]) on the [NAME] Hall related to the Packaged Terminal Air Conditioner (PTAC) air filters containing a significant amount of gray, fuzzy particulate matter. This deficient practice had the potential to contribute to respiratory problems for residents due to unclean air filters.Findings included:During an observation on 4/21/2026 at 11:20 am, the PTAC air filters in room [ROOM NUMBER] of the [NAME] Hall contained a significant amount of gray, fuzzy particulate matter. During an observation on 4/21/2026 at 11:37 am, the PTAC air filters in room [ROOM NUMBER] of the [NAME] Hall contained a significant amount of gray, fuzzy particulate matter.During an observation on 4/21/2026 at 12:23 pm, the PTAC air filters in room [ROOM NUMBER] of the [NAME] Hall contained a significant amount of gray, fuzzy particulate matter.During an observation on 4/22/2026 at 11:47 am with the Maintenance Director, he confirmed that the PTAC air filters in rooms [ROOM NUMBER] were soiled with a significant accumulation of particulate matter. The Maintenance Director acknowledged that the filters required cleaning and stated that the PTAC filter cleaning is assigned to the Environmental Services Director (ESD). He stated that the task should be completed during the room deep-cleaning process. However, he was unable to specify the exact frequency of these cleanings. He further stated that he maintains oversight responsibility for ensuring the task is completed and indicated that the cleaning schedule may need to be reviewed and adjusted to ensure consistency. He confirmed that failure to properly maintain PTAC filters may impact system functionality and potentially compromise indoor air quality, which could affect the air that residents breathe. During an interview on 4/23/2026 at 12:19 pm, the Director of Nursing (DON) stated that the PTAC filters should be serviced and cleaned, as respiratory issues can arise from breathing dirty air filters.During an interview on 4/24/2026 at 3:08 pm, the EVS Director revealed that the air filters in the identified resident rooms have now been cleaned. He stated that, before this, filter cleaning was not performed on a routine schedule because no specific staff member had been assigned responsibility. Instead, filters were only cleaned during room deep cleaning, which occurred intermittently when rooms became vacant, ranging from approximately one week to up to three months or more. The EVS Director further stated that a corrective action has been implemented, with a designated staff member now assigned to clean air filters on a monthly basis to ensure ongoing maintenance.A review of the facility policy titled Physical Environment: Electrical Equipment, undated, revealed that the facility will maintain all mechanical, electrical, and patient care equipment in safe operating condition. Further review revealed that the Maintenance Director shall maintain schedules for routine inspection and maintenance of all mechanical, electrical, and patient care equipment and that documentation of inspection, testing, and maintenance of electrical equipment shall be maintained for a minimum of three years.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and resident interviews, and review of facility policy titled Resident Assessment-Coordination with PASARR Program, the facility failed to ensure a Preadmission Screening and Resident Review (PASARR) Level II was submitted for two of four sampled residents (R) (R3 and R7) reviewed for PASARR II. This deficient practice had the potential to place residents at increased risk of not receiving the required behavioral health support to meet their daily needs. Findings included:1. During an observation and interview on 4/21/2026 at 12:23 pm with R3 revealed she was admitted to the facility following a lithium overdose related to her diagnosis of bipolar disorder and reported a need for better medication regulation. R3 stated that during her stay, she recalls only one interaction related to her mental health, describing it as a one-time psychiatric evaluation/consult. She reported that she is not currently receiving ongoing mental health services and does not see a mental health provider regularly. R3 further stated that she previously received regular mental health support and expressed that she would benefit from ongoing mental health services to address her current needs. A review of the electronic medical record (EMR) revealed R3 was admitted to the facility on [DATE] and pertinent diagnoses, including but not limited to bipolar disorder, unspecified; manic episode, unspecified; dementia with behavioral disturbance; altered mental status; disorientation, unspecified; cognition communication deficit. A review of R3's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. Section I (Active Diagnoses) documented diagnoses including bipolar disorder and non-Alzheimer's dementia, and Section N (Medications) indicated the resident was receiving antipsychotic, antidepressant, and anticonvulsant medications. A review of R3's care plan dated 4/6/2026 identified problems, including bipolar disorder with mood instability, behavioral symptoms (agitation, verbal aggression, and confusion), cognitive impairment/dementia with impaired decision-making, use of psychotropic medications, wandering/elopement risk, insomnia, and pain management needs. Goals included maintaining psychiatric stability with no depressive or manic episodes, reducing maladaptive behaviors such as agitation, verbal aggression, and confusion, improving coping skills, ensuring safety and preventing elopement, maintaining adequate sleep patterns, and supporting communication of basic needs while minimizing behavioral escalation. Interventions included administering mood stabilizers and psychotropic medications as ordered, with monitoring for effectiveness and adverse effects, identifying and addressing behavioral triggers, and implementing de-escalation techniques and calm redirection strategies. Additional interventions included maintaining a structured and low-stimulation environment, using simple and consistent communication techniques, reorienting and cueing the resident as needed, ensuring basic needs such as pain, toileting, and hunger are addressed promptly, and reinforcing participation in care. Wandering precautions were implemented through monitoring, redirection, and safety interventions. Psychosocial and psychiatric supports included psychiatric consultation and pharmacy review as needed. Medication management interventions included ongoing monitoring of psychotropic medications for side effects and effectiveness, and implementation of non-pharmacological behavioral interventions to support overall mental and behavioral stability. A review of the Physician Orders for R3 included, but was not limited to: (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Order dated 2/24/2026 for Depakote Delayed Release (Divalproex Sodium) 250 milligrams (mg): give one tablet two times a day for bipolar manic symptoms. Order dated 3/19/2026 for Olanzapine 5 mg: give one tablet at bedtime for manic depression. Order dated 3/26/2026 for Citalopram 10 mg: give one tablet one time a day for depression. Order dated 3/25/2026 for Trazadone 50 mg: give 0.25 at bedtime for depression, anxiety Order dated 11/26/2025 for Behavior-monitoring Order dated 11/26/2025 for antipsychotic medication monitoring. Order dated 11/26/2025 for psychiatric services to evaluate and treat as indicated A review of R3's psychiatric consults dated 4/1/2026 and 4/21/2026 (with prior visits on 3/17/2026 and 4/14/2026) revealed ongoing bipolar disorder management with psychotropic medications and continued monitoring needs due to mood instability, cognitive impairment, and history of confusion and falls, supporting the need for ongoing psychiatric oversight. A review of the facility's PASARR tracking documentation and census listing for PASARR Level II determinations revealed R3 was not included on the facility's PASARR Level II tracking list. A review of the EMR also failed to reveal evidence that a PASARR Level II evaluation or determination had been completed for R3. During an interview on 4/23/2026 at 1:06 pm with the Social Services Director regarding PASARR (Level I and Level II), it was revealed that Social Services may submit PASARR requests when there is a change in condition after admission, and indicated that the facility is currently refining its PASARR process with a formalized procedure expected to be implemented within the next week. The Director further stated that residents requiring a PASARR Level II evaluation must be identified and evaluated. He confirmed that R3 requires submission for a PASARR Level II, noting the resident has been in the facility since November 2025 and that the request would be submitted on the date of the interview. An interview on 4/23/2026 at 2:42 pm with the Director of Nursing (DON) revealed that a PASARR Level II is required for residents with qualifying diagnoses such as bipolar disorder or other serious mental illnesses. She stated that Social Services is responsible for evaluating residents for PASARR Level II upon admission, and that this process is also reviewed during interdisciplinary meetings. The DON provided the surveyor with documentation confirming that a PASARR Level II request for R3 was submitted on the date of the interview. A review of the facility policy titled Resident Assessment-Coordination with PASARR Program, revised April 2026, item 1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. Further review of item 5. If a resident who was not screened.and the resident remains in the facility longer than 30 days: b. The Level II resident review must be completed within 40 calendar days of admission. Item 6. The Social Services Director shall be responsible for keeping track of each resident's PASSAR screening status and referring to the appropriate authority. Item 7. Recommendations, such as any specialized services, from a PASARR Level II determination and/or (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASSAR evaluation report, will be incorporated into the resident's assessment, care planning, and transitions of care. 2. A review of the EMR revealed R7 was admitted to the facility on [DATE] and pertinent diagnoses, including but not limited to mood disorder, major depressive disorder, anxiety disorder, and altered mental status. A review of R7's quarterly MDS assessment dated [DATE] revealed a BIMS score of four, indicating severe cognitive impairment. Section E (Behavior) documented physical behavioral symptoms directed towards others: behavior of this type occurred one to three days. A review of R7's care plan identified problems, including verbal aggression towards staff members and impaired cognitive function due to intellectual disability. Interventions included Psychiatric/Psychogeriatric consult as indicated; monitor/document/report PRN (as needed) any changes in cognitive function, specifically changes in: decision making ability, memory, recall, and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. Medication management interventions included ongoing monitoring of antidepressant medications for side effects and effectiveness. A review of the Physician Orders for R7 included, but was not limited to: sertraline HCl Oral Tablet 50 mg (Sertraline HCl) - Give one tablet by mouth one time a day for Depression Apixaban Oral Tablet 5 mg (Apixaban) - Give 1 tablet by mouth two times a day for atrial fibrillation Seroquel Oral Tablet 50 mg (Quetiapine Fumarate) - Give 1 tablet by mouth at bedtime for refractory depression Psychiatric services to evaluate and treat as indicated A review of R7's psychiatric consults dated 4/14/2026 (with prior visit on 2/17/2026) revealed ongoing mood disorder management with antidepressant medications and continued monitoring due to mood and behavior instability. A review of the facility's PASARR tracking documentation and census listing for PASARR Level II determinations revealed R7 was not included on the facility's PASARR Level II tracking list. A review of the EMR also failed to reveal evidence that a PASARR Level II evaluation or determination had been completed for R7. During an interview with the Social Services Director (SSD) on 4/23/2026 at 1:50 pm confirmed that R7 had qualifying diagnoses for a PASARR Level II evaluation and should have been assessed accordingly. The SSD stated that the facility recently received PASARR training the prior week and was still in the process of determining the appropriate procedures. The SSD further revealed that a request for a PASARR Level II evaluation for R7 had not been submitted promptly and would be submitted on 4/23/2026.

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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. Based on observations, interviews, record reviews, and the facility policy titled Oxygen Administration, last revised on 1/20/2025 the facility failed to ensure proper maintenance and monitoring of oxygen equipment, in accordance with professional standards of practice for one of 41 sampled residents (R) (R50) reviewed for respiratory care related to maintaining a clean oxygen concentrator filter and ensuring the appropriate setup of oxygen equipment, including the presence of a humidifier bottle. This deficient practice had the potential to result in decreased oxygen delivery, increased risk of respiratory compromise, and exposure to contaminants, which could adversely affect the resident's health and safety. Findings included: During an observation on 4/21/2026 at 1:11 pm, the resident was observed lying in bed receiving oxygen via nasal cannula at 4 liters per minute (L/min). Observation of the oxygen concentrator revealed the filter to be visibly soiled with an accumulation of dust. The nasal cannula tubing was not dated, and no humidification device was observed in use with the oxygen delivery system.During a second observation on 4/22/2026 at 11:00 am, the resident was again observed receiving oxygen via nasal cannula. The oxygen flow rate was observed at 3 L/min, and the tubing was dated. However, the oxygen concentrator filter remained visibly dirty, with no evidence of cleaning or replacement.During an interview on 4/22/2026 at 2:00 pm, a Certified Nursing Assistant (CNA) stated that she ensures oxygen tubing is clean and that oxygen is set at the correct flow rate as ordered. She reported that oxygen supplies are stored in a plastic bag in the resident's room.During an interview on 4/22/2026 at 2:20 pm, the Unit Manager (RN) stated that oxygen concentrators are monitored daily for proper function. She reported that concentrator filters are checked weekly and that tubing is changed and dated by night shift staff.During a third observation on 4/23/2026 at approximately 9:30 am, the resident was observed in bed receiving oxygen via nasal cannula at 3 L/min. The tubing was intact and dated appropriately. The resident appeared alert, with respirations even and unlabored, and no signs of acute respiratory distress were noted. The oxygen concentrator was functioning without alarm; however, the filter remained visibly soiled with accumulation of dust, indicating continued lack of maintenance.During an interview on 4/23/2026 at 9:30 am, a Licensed Practical Nurse (LPN) stated that oxygen tubing is changed weekly and as needed, with routine changes completed by night shift staff who also date the tubing. She further stated that oxygen concentrators should include a humidifier bottle when indicated and that water levels should be monitored. When shown the oxygen concentrator in use without a humidifier bottle and with a visibly soiled filter, the LPN confirmed that the humidifier bottle was not present and that the filter required cleaning.During an interview on 4/23/2026 at 1:15 pm, the Director of Nursing (DON) confirmed that staff are expected to ensure oxygen is administered as ordered and that oxygen concentrators are maintained in proper working order. She further stated that tubing is to be changed and dated weekly and that filters are to be checked, cleaned, or replaced on a weekly basis. When shown the condition of the oxygen concentrator filter, the DON confirmed that it was dirty and required cleaning or replacement.A review revealed the resident had diagnoses, including, but not limited to, Chronic Obstructive Pulmonary Disease (COPD), shortness of breath, and dependence on supplemental oxygen. Physician orders directed oxygen administration at 3 L/min via nasal cannula and included monitoring for respiratory distress and maintaining oxygen therapy as ordered.Care plan interventions included monitoring for signs and symptoms of respiratory compromise, including shortness of breath, changes in oxygen saturation, restlessness, confusion, and other indicators of respiratory insufficiency, as well as ensuring oxygen was administered as ordered. Further review revealed facility practice required oxygen tubing to be changed and dated weekly, and oxygen concentrator filters to be checked, cleaned, or replaced on a routine basis.A review of the Oxygen Administration policy dated 4/1/2023 and last revised 1/20/2025 revealed that oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the residents' goals and preferences.