STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115443	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Knoll Path of Journey LLC	156 Pine Knoll Drive Carrollton, GA 30117

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews, and review of the facility policy titled, Food Safety Requirements, the facility failed to ensure the kitchen environment was maintained in a safe, clean, and sanitary manner to prevent foodborne illness. These deficient practices had the potential to affect 96 of 100 residents receiving oral diets from the kitchen.Findings include: Review of the facility's policy titled Food Safety requirements, dated 2/1/2024, documented, It is the policy of this facility to procure food from sources approved or considered satisfactory by federal, state, and local authorities. Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety. In addition, the Policy Definition of Contamination means, The unintended presence of potentially harmful substances including, but not limited to microorganisms, chemicals, or physical objects. Documented in the Policy Explanation and Compliance Guidelines, number 1 (b) Storage of food in a manner that helps prevent deterioration or contamination of food, including from growth of organisms., and number 7 (d) Dietary staff must wear hair restraints (e.g., hairnet, hat, and/or beard restraint hair to prevent hair from contacting food.Upon entry into the kitchen for initial observation tour on 05/17/2026 at 12:30 PM, Food Service Manager (FSM) was on the serving line for the lunch meal, so the Administrator completed the tour on the FSM's behalf and revealed the following:A ventilation grate under the three-compartment sanitation sink which contained a significant accumulation of gray particulate matter. The Administrator confirmed the observation and indicated the vent required cleaning. Five opened cans of diced peaches containing juices were sitting next to the kitchen ice machine. The Administrator confirmed the observation; but was unaware why the cans had not been properly disposed.A brown substance on wall of dry storage area by shelving for canned goods. Administrator confirmed the observation but was unable to identify what the brown substance was or its source. She stated the wall would be cleaned promptly. During a secondary tour of the kitchen on 05/18/2026 at 9:11 AM, the FSM confirmed the dirty ventilation grate had the potential for food contamination. She stated she was unsure who was responsible for cleaning the grates; but would ensure it was cleaned at least every three months. In addition, the FSM stated the peaches were served for a meal the prior day and the Activity Department asked Dietary staff to save the cans for an activity project. Otherwise, the cans would have been disposed of in the trash.On 05/18/2026 at 9:21 AM, during the interview and observation with FSM, the wall had not yet been cleaned. FSM indicated she thought the substance was chocolate. On 05/19/2026 at 12:59 PM, interview and observation with Dishwasher (DW) DW KK revealed he had facial hair and was not wearing a beard restraint. DW KK stated he had worked in the department almost a year and was aware of the importance of wearing a hair restraint to prevent hair from contaminating foods and food surfaces. The FSM confirmed the observation. On 05/19/2026 at 1:05 PM, a fan was observed pointing in the direction of clean dishes in the dishwasher area. The fan had a significant accumulation of gray particulate matter on the grill. DW KK stated he uses the fan to help dry the dishes after they are washed. This observation was confirmed by the FSM who took the fan out of service for immediate cleaning. On 05/20/2026 at 2:39 PM, interview with the FSM and Administrator revealed the Administrator had held a QAPI (Quality Assurance Performance Improvement) meeting to (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
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	discuss the potential sanitation observations in the kitchen. The Administrator stated she expected all parts of the kitchen to be clean and in good repair, items should be appropriately labeled, dated and stored properly. All items were cleaned and, anything that needed to be disposed of would be disposed of properly. The Administrator stated staff were expected to be well trained and have competencies in maintaining a clean and safe kitchen environment to serve residents. On 05/20/2026 at 4:41 PM, observation of Dietary Aide (DA) DA LL revealed he had facial hair and was not wearing a beard restraint. DA LL secured a beard restraint after the observation was brought to the attention of the FSM.

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observations, and staff interviews, the facility failed to ensure the outdoor garbage and refuse area was maintained in a sanitary manner. The deficient practice increased the risk of attracting and harboring pests. The facility census was 100. Findings include: Upon entry into the kitchen for initial observation tour on 05/17/2026 at 12:30pm, Food Service Manager (FSM) was on the serving line for the lunch meal, so the Administrator completed the tour on the FSM's behalf and revealed the following observations of the outside refuse and dumpster area:Cardboard boxes were overflowing from a gray colored trash receptacle without a lid. The Administrator confirmed the cardboard boxes were improperly disposed of and uncovered. She stated the boxes were from a Central Supply Department delivery on Friday [05/15/2026], and the Central Supply Manager normally breaks down boxes for disposal. [NAME] sink was lying on the dumpster platform next to the dumpster. The Administrator confirmed the observation and stated the Maintenance Director had removed the sink from the kitchen by the ice machine on Friday [05/15/2026] and left the sink on the dumpster platform. The Administrator stated that Maintenance was creating a secondary Food Preparation Station in the kitchen. Three bread trays were on the ground propped against the outdoor freezer unit with a trash lid propped on top. The Administrator confirmed the observation but was unclear as to why the racks were situated in the area. 05/20/2026 at 2:39 PM, interview with the FSM and Administrator revealed the Administrator had held a Quality Assurance Performance Improvement (QAPI) meeting to discuss the dumpster and refuse areas. The Administrator stated anything that needed to be disposed of would be disposed of properly. The Administrator stated staff will be trained and complete competencies in maintaining a clean and safe environment. A Dumpster Sanitation and Refuse Policy was requested but not provided by the facility.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, record review, and review of the facility's policy titled, Catheter Care, the facility failed to perform catheter care using proper cleaning technique for one of four sampled residents (R) (R48). This deficient practice increased the risk of urinary tract infection (UTI), resistant bacterial strains, and sepsis for R48. Findings include:Review of the electronic medical record (EMR) revealed that R48 was admitted to the facility on [DATE], with pertinent diagnoses including, but not limited to, pressure ulcer of the sacral region, stage 4, and pressure ulcer of the left heel, stage 4.Review of R48's Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) of 15, which indicated little to no cognitive impairment. Section GG, functional status, revealed that the R48 used a wheelchair for mobility and required setup and cleanup for meals and oral hygiene. R48 was dependent on staff for toileting, hygiene, showering, and bathing and required substantial assistance with upper and lower body dressing.Review of R48's care plan dated 05/06/2026, documented a problem of, I have a (Foley) Catheter r/t {related to} pressure ulcer. Interventions included, but were not limited to: Check tubing for kinks each shift with CNA (Certified Nursing Assistant) responsibleEmpty Foley catheter every Shift and prn (as needed)Foley cath strap in placeFoley catheter care every shiftObserve/document for pain/discomfort due to the catheter Observe/record/report to MD {physician} for s/sx {signs and symptoms} UTI: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul-smelling urine, fever, chills, altered mental status, change in behavior, and change in eating patterns.Review of Physician's Orders for R48 included, but were not limited to:Catheter care every shift and PRN every shiftCatheter: Foley catheter 16FR (French) with 10ml {milliliter} balloon to bedside bag r/t stage 4 sacral woundFoley catheter: may change Foley PRN as needed for woundDuring an observation and interview on 05/19/2026 at 3:34 PM, R48 confirmed the Foley catheter bag at bedside. During an observation on 05/19/2026 at 9:10 AM of R48's Foley care, performed by CNA AA revealed R48 was lying in bed. Permission from R48 was granted for surveyor observation. CNA AA was already in the room, wearing a gown and gloves, and had just finished incontinence care on the roommate. CNA AA stated R48 was wet, the catheter was leaking, and there was a moderate amount of urine in the tubing at this time. CNA AA pulled R48's covers back, and there was a Foley tubing holder on R48's right leg, but the tubing was not secured to it. CNA AA emptied the catheter bag into a urinal, and while dumping the urine, she left the catheter bag on the bed above the level of the bladder and left the resident exposed. She returned wearing the same gloves, did not perform hand hygiene, and took some wipes from the resident's bedside table. With one wipe, she wiped the resident's outer labia area from front to back, then trailed back to the front with the same wipe. Then, with the same wipe, she wiped the Foley tubing from distal to proximal toward the urinary meatus. When asked if this is her normal way of performing Foley and peri care, CNA AA stated that she usually uses a bath basin and a washcloth, and it's done during her bed bath, but the water was slow to get warm this morning. When asked about cleaning the inner labia, CNA AA obtained another wipe and cleaned them from front to back.During an interview with Licensed Practical Nurse CC on 05/19/2026 at 10:10 AM, she confirmed that her process for Foley catheter care and her expectation was the CNA perform Foley care every shift and use proper hand hygiene and personal protective equipment (PPE). They should either use warm water and wash clothes or wipes and first wash the outer labia from front to back. Then, with a clean part of the washcloth or a new wipe, clean the inner labia from front to back. Then, with another clean washcloth or wipe, wash the Foley tubing from the urinary meatus outward and clean the tubing. During an interview with the Infection Preventionist LPN on 05/19/2026 at 10:15 AM, confirmed that her process for foley care was the CNA should perform hand hygiene, and wear (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	proper PPE (personal protective equipment) and first clean posterior area first if there is a bowel movement then remove gloves and perform hand hygiene and apply clean gloves and start with a clean wash cloth and warm water or a clean wipe and clean the labia and then with a new wipe clean the catheter and wipe the tubing away from the urethra.During an interview with the Director of Nursing (DON) on 05/20/2026 at 2:00 PM, it was confirmed that further education was needed for the CNAs on catheter care. The DON stated her expectations for Foley catheter care were that all tubing is secured with a securement device and that Foley care was aseptic and performed every shift.Review of the facility's policy titled Catheter Care, revised 11/5/2025, section under Compliance Guidelines revealed under female care.8. Gently separate the labia to expose the urinary meatus. 9. Wipe from front to back with a clean cloth moistened with water and perineal cleaner or soap. 10. Use a new part of the cloth or a different cloth for each side. 11. With a new moistened cloth, starting at the urinary meatus, moving out, wipe the catheter, making sure to hold the catheter in place so as not to pull on the catheter. 12. Dry area with a towel.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, record reviews, and review of facility policy titled, Oxygen Concentrator, the facility failed to ensure the respiratory equipment and supplies were maintained, administered, and available according to standards of practice for five of 30 residents (R) (R5, R41, R101, R13, and R23), sampled for respiratory care. Specifically, the facility failed to maintain clean oxygen (O2) concentrator filters, remove surface dirt from the O2 concentrator, ensure the nasal cannula was connected to the O2 humidification bottle, and failed to keep an additional tracheostomy tube at the bedside. These deficient practices had the potential to place residents at risk for respiratory infection, blood O2 desaturation, and delayed intervention for a respiratory emergency. Findings include: 1. Observation conducted on 05/17/2026 at 3:10 PM revealed that R5 was receiving oxygen at 2 liters per minute (LPM) via nasal cannula (NC) from an O2 concentrator (self-contained device used to produce oxygen.) The oxygen concentrator filter was visibly dirty, with dust and lint accumulated on its surface. Observations conducted on0 5/18/2026 at 8:50 AM, revealed that R5 was receiving O2 at 2 LPM via NC from an O2 concentrator, and the concentrator filter was visibly dirty, with dust and lint accumulated on its surface. During a review of the electronic medical record (EMR), it was revealed that the R5 was admitted to the facility on [DATE], with pertinent diagnoses, which included, but not limited to, chronic respiratory failure with hypoxia, congestive heart failure (CHF), and shortness of breath (SOB.) During a record review of physician orders for R5, it was documented: O2 at 2 LPM via NC, related to CHF for every shift, dated 04/06/2026. Change oxygen tubing and set up weekly, one time a day every Sunday for Chronic Obstructive Pulmonary Disease (COPD), dated 05/10/2026. During a record review of the care plan for R5, it was documented, I have altered respiratory status r/t {related to} CHF, chronic respiratory failure with hypoxia, and SOB. In addition, I will have no complications related to SOB through the review date, and Observe and document changes in orientation, increased restlessness, anxiety, and air hunger. During an Observation on 05/18/2026 at 2:15 PM, revealed R5 was receiving oxygen at 2 LPM via NC through an O2 concentrator. The concentrator filter remained visibly soiled with accumulated dust and lint, while the resident continued to use the equipment. 2. Observation conducted on 05/17/2026 at 1:00 PM, revealed that R41 was receiving O2 at 2 LPM via NC from an O2 concentrator. The O2 concentrator filter was visibly dirty, with dust and lint accumulated on its surface. Observation conducted on 05/18/2026 at 8:50 AM, revealed that R41was receiving O2 at 2 LPM via (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NC from an O2 concentrator, and the concentrator filter was visibly dirty, with dust and lint accumulated on its surface. During a review of the EMR, it was revealed that R41 was admitted to the facility on [DATE], with pertinent diagnoses which included, but not limited to, COPD, unspecified asthma uncomplicated, chronic respiratory failure with hypoxia, and SOB. During a record review of physician orders for R41, it was documented: O2 at 2 LPM via NC, as needed to maintain O2 saturation above 92% {percent} related to SOB dated 05/07/2026. Check O2 saturation (SpO2) every shift as needed, dated 05/07/2026. During a record review of the care plan for R41, it was documented that R41 had altered respiratory status related to COPD, asthma, chronic respiratory failure with hypoxia, allergic rhinitis, SOB, and history of COVID19. In addition, the care plan documented, Oxygen at 2 liters per minute via nasal cannula as needed to maintain oxygen saturation above 92%. During an Observation on 05/18/2026 at 2:15 PM, revealed R41 was receiving O2 at 2 LPM via NC through an O2 concentrator. The concentrator filter remained visibly soiled with accumulated dust and lint, while the resident continued to use the equipment. 3. Observation conducted on 05/17/2026 at 2:44 PM, revealed that R101 was receiving O2 at 3 LPM via NC from an O2 concentrator. The O2 concentrator filter was visibly dirty, with dust and lint accumulated on its surface. Observation conducted on 05/18/2026 at 8:50 AM, revealed that R101 was receiving oxygen at 3 LPM via NC from an O2 concentrator, and that the concentrator filter was visibly dirty, with dust and lint accumulated on its surface. Observation conducted on 05/18/2026 at 2:15 PM, revealed the O2 concentrator was in use by R101, and the concentrator filter remained visibly covered with dust and lint. During a review of the EMR, it was revealed that R101 was admitted to the facility on [DATE], with pertinent diagnoses which included, but not limited to, acute and chronic respiratory failure with hypercapnia, COPD, chronic atrial fibrillation, SOB, chronic respiratory failure with hypoxia, and CHF. During a record review of physician orders for R101, it was documented: O2 at 3 LPM via NC every shift to keep O2 level above 92% or SOB dated 03/09/2026. During a record review of the care plan for R101, it was documented that R101 was noted to have altered respiratory status related to CHF, COPD, acute on chronic respiratory failure with hypoxia and hypercapnia, respiratory acidosis, Influenza B, sleep apnea, SOB, and history of COVID-19. Interventions included monitoring for shortness of breath, cyanosis, labored breathing, use of accessory muscles, and other signs of respiratory distress, with physician notification as needed. The care plan further documented O2 administration at 3 LPM via NC and a goal for the resident to remain free from respiratory complications through the review date. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interviews on 05/18/2026, at 1:40 PM, Certified Nursing Assistants (CNA) CNA EE and CNA FF stated that residents receiving oxygen therapy were monitored for respiratory distress, oxygen equipment issues, and changes in condition, and that any concerns were reported to nursing staff promptly. During an interview on 05/18/2026 at 1:45 PM, Licensed Practical Nurse (LPN) LPN GG stated oxygen concentrators were monitored to ensure the equipment remained functional and humidification bottles did not become dry. She stated that an outside company cleaned the oxygen concentrator filters and further stated that residents who received oxygen therapy were monitored for signs of respiratory distress and changes in oxygen status. During an interview on 05/18/2026 at 2:15 PM, Unit Manager LPN HH confirmed the concentrator filter observed in use by R5 was really very dirty and stated she would address it immediately. During an interview on 05/18/2026 at 2:25 PM, the Administrator confirmed the filters were visibly soiled and stated that the facility used an outside vendor to maintain the oxygen concentrators approximately every three months. During an interview on 05/19/2026 at 9:22 AM, with the Director of Nursing (DON), she was informed that observations noted visible accumulations of dust and lint on O2 concentrator filters. The DON confirmed that the concentrator filters were soiled and that O2 administration equipment should be maintained in a clean and sanitary condition. She stated that her expectation was for staff to routinely monitor, clean, and maintain O2 concentrator filters to ensure proper functioning of the equipment and to reduce the risk of infection control concerns and compromised respiratory care for residents receiving oxygen therapy. During a record review of the document titled, Rental and service contract, between [name of contracted group] and Pine [NAME] Nursing and Rehab Center, dated 5/7/2024, under EXHIBIT A, documented: The company will perform the following services upon request of the client.2.c provide orientation for all company employees, agents or representatives.2. Ensure company employees fully comply with the policies and procedures of the company and client.3. Perform preventative maintenance and services to all client-owned and rented oxygen concentrators and equipment on schedule determined by the client and company, including but not limited to filter changes. During a record review of the facility's policy titled, Oxygen Concentrator, dated 2/1/2024 and revised 2/16/2024, documented, .1. Staff responsible for the use and care of oxygen concentrators receive training on oxygen safety and functionality of the device.2. Oxygen is administered under orders of the attending physician except in the case of an emergency.3. The nurse shall verify the physician's orders for the rate of flow and route of administration of oxygen (mask, nasal cannula, etc.) .5. a Follow the manufacturer's recommendation for the frequency of cleaning filters and servicing the device.5c.4 The main body cabinet should be dusted when needed and can be wiped clean with a damp cloth and mild household cleaner if necessary.5. f The oxygen concentrator should have a preventive maintenance due sticker with an expiration date. 4. Review of the EMR for R13 revealed, she was admitted to the facility with diagnoses, that included, but not limited to, gastrostomy status, anoxic brain damage, tracheostomy status, and chronic respiratory failure with hypoxia. Observation on 05/18/2026 at 10:36 AM revealed, R13 was lying in her bed breathing through a (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tracheostomy (trach) tube with O2 bled (connected to the tracheostomy tubing) at 2 LPM. She was in no apparent distress. The O2 concentrator was dirty and there was no additional trach tube at the bedside for emergency use. Observation on 05/19/2026 at 11:00 AM revealed that R13 was lying in her bed breathing without distress through a trach tube with O2 bled in at 2 LPM. The O2 concentrator was dirty and there was no additional trach tube at the bedside for emergency use. Observation on 05/20/2026 at 11:35 AM with LPN GG, confirmed the dirt on the surface of the O2 concentrator and the absence of an additional trach tube at the bedside. She stated the O2 concentrator surface should be wiped down at least weekly with the change of supplies and there should always be an extra trach tube at the bedside for emergency use. 5. Review of the facility's policy titled, Oxygen Administration, revised 2/14/2024, section titled Policy Explanation and Compliance Guidelines: documented, . 1. Oxygen is administered under the orders of a physician. Review of the EMR revealed R23 was admitted to the facility on [DATE], with pertinent diagnoses, which included, but not limited to, COPD, respiratory failure with hypoxia, diastolic heart failure, and obstructive sleep apnea (OSA.) Review of R23's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 15, which indicated little to no cognitive impairment. Section GG, functional status, revealed that R23 required maximum staff assistance for activities of daily living (ADLs), with two-person assistance for transfers, baths, dressing, and turning. Review of R23's care plan dated 05/08/2026, indicated a problem of altered respiratory status r/t chronic respiratory failure, COPD, CHF, Bronchitis, history of OSA, SOB, allergic rhinitis, and cough. Interventions included, but were not limited to: Administer medication/puffers as ordered. Monitor for effectiveness and side effects. Maintain a clear airway by encouraging the residents to clear their own secretions with effective coughing. If secretions cannot be cleared, suction is ordered or required. Monitor /document changes in orientation, increased restlessness, anxiety, and air hunger. Monitor for s/sx (signs and symptoms) of respiratory distress and report to MD (physician) PRN (as needed): Increased Respirations; Decreased Pulse oximetry; Increased heart rate (Tachycardia); Restlessness; Diaphoresis; Headaches; Lethargy; Confusion; Hemoptysis; Cough; Pleuritic pain; Accessory muscle usage; Skin color changes to blue/grey. OXYGEN SETTINGS: O2 2 LPM via nasal cannula continuously to keep SpO2 above 92% uses 2 or more pillows due to SOB r/t COPD. Review of the Physician's Orders for R23, dated 04/07/2026 included, but was not limited to, 02 at 2LPM via nasal cannula continuously to keep Sp02 above 92%. During an observation on 05/17/2026 at 2:15 PM with R23, it was revealed she was alert and oriented and pleasant, lying in bed, with good hygiene. She was wearing 02 via NC at 3.5 LPM. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 05/19/2026, at 11:50 AM, R23 was in her room and stated there was no air coming through her NC. On further investigation, the O2 concentrator was covered with a blanket and a lift pad, and the LPM was 3.5 LPM. An interview with LPN BB on 05/19/2026 at 12:00 PM confirmed that when we entered R23's room, after removing the blankets and lift pad from R23's O2 concentrator, the hose from the concentrator to the humidifier bottle was not attached, and the resident was not getting any oxygen. LPN BB measured R23's SpO2, which registered 88%. LPN BB confirmed that the concentrator was set to 3.5 LPM, and her physician's order is for 2 LPM. LPN BB stated that they check the oxygen flow on the concentrators every shift. An interview with the DON on 05/20/2026 at 11:38 AM revealed that she believed the resident could adjust the LPM on the concentrator herself. The DON stated her expectation for checking 02 LPM on all the concentrators was that it should be done every shift by the charge nurses.