STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115565	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stone Mountain Run of Journey LLC	5160 Spring View Avenue Stone Mountain, GA 30083

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 maintain the cleanliness of the facility minimizing the risk of food-borne illness and to promote safe food handling practices. The deficient practice had the potential to place 27 of 27 residents who received an oral diet at risk of foodborne illness.Findings Include:Review of the facility policy titled Food Safety Requirements revealed under Policy Explanation and Compliance Guidelines: .7. Staff shall adhere to safe hygiene practices to prevent contamination of foods from hands or physical objects. 8. Additional strategies to prevent foodborne illness include, but are not limited to: . e. Cleaning and sanitizing the internal components of the ice machine according to manufactures guidelines.Observation on 05/04/26 at 10:40 AM of the ice machine located in the kitchen revealed that the unit had a build-up of a tan like thick substance attached to the top and bottom of the inside of the ice machine. There was an off white, tan drip on the front lid's left side.An interview on 05/04/2026 at 10:45 AM with the Dietary Manager confirmed the build-up inside the unit. She reported that maintenance cleaned the ice machine.An observation and interview on 05/05/2026 at 10:30 AM with the District Manager confirmed the build-up on the inside of the unit.An observation on 05/05/2026 at 10:35 AM revealed the ice machine had been cleaned of the build-up.Observation on 05/04/2026 at 10:50 AM of the portable air conditioners in the kitchen. Two units were in use with a thick black flaky substance blowing from the unit. The build-up/substances on one of the units was blowing toward the food line.An interview on 05/04/2026 at 10:55 AM with the Dietary Manager confirmed the build-upon the portable air conditioners and the unit blowing toward the food line. The units were turned off and taken to be cleaned by maintenance.An interview on 05/05/2026 at 10:35 AM with the Dietary Manager confirmed the picture of the unit had a build-up of a black flaky substance blowing toward the food tray line.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 and staff interviews, the facility failed to ensure that it was maintained in a safe, clean and comfortable home-like environment were clean and free from dusty grayish build up including on packaged terminal air conditioner (PTAC) in air conditioner (AC) units on six of six halls (100 Hall, 200 Hall, 300 Hall, 400 Hall, 500 Hall and 600 Hall) in 18 resident rooms (Rooms 201,208, 221, 316, 401, 405, 407, 411, 413, 507, 508, 511, 512, 602, 606, 611, 701, and 713), The deficient practice had the potential to cause respiratory issues for residents residing in the affected rooms Findings include:A review of facility documentation titled Direct Supply TELS (building management platform) dated 02/28/2026 revealed Instructions on HVAC (PTAC), due 05/31/2026: Clean air filter. Step 1. Remove or open access cover. 2. Remove air filter and inspect for cleanliness. If filter is dirty, either wash or replace depending on type of filter. Observation on 05/04/2026 during Initial screening starting at 10:47 AM till 1:33 PM on the 200, 300, 400, 500, 600 and 700 hall revealed an excessive amount of gray fuzzy substance on pull out vent filters in the following rooms: room [ROOM NUMBER]room [ROOM NUMBER] room [ROOM NUMBER] room [ROOM NUMBER] room [ROOM NUMBER] room [ROOM NUMBER]room [ROOM NUMBER]room [ROOM NUMBER]room [ROOM NUMBER]room [ROOM NUMBER]room [ROOM NUMBER]room [ROOM NUMBER]room [ROOM NUMBER]room [ROOM NUMBER]room [ROOM NUMBER]room [ROOM NUMBER]room [ROOM NUMBER]room [ROOM NUMBER]During a tour starting on the 200 hall on 05/04/2026 at 4:52 PM with the Regional [NAME] President of Operations (RVPO) and the Administrator confirmed that the PTAC air conditioning unit in room [ROOM NUMBER] exhibited a grayish buildup on the filter. Both parties acknowledged this issue and agreed that cleaning would be performed right away; however, they declined to continue the tour of the other rooms mentioned. The Administrator indicated that the PTAC units were inspected weekly and cleaned monthly but noted that the condition of the filter posed a risk of respiratory complications for residents.An interview and observation on 05/05/2026 at 9:42 AM with the Regional Maintenance Director (RMD), who was shown several images via phone showing dust accumulation on PTAC units in rooms 201, 208, 221, 401, 405, 407, and 606. The RMD confirmed that the dust buildup was present for two to three months. He disclosed that he performed cleaning on 02/26/2026 but acknowledged that he did not believe he was able to clean the PTAC units during the task log that was marked as completed on time for Category HVAC PTACs.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, record review, and review of the facility policies titled, Comprehensive Care Plan and Oxygen Administration, the facility failed to develop a comprehensive care plan for two of 59 sampled residents (R) (R101 and R108). Specifically, R101 was receiving continuous oxygen, and it was not addressed on the care plan and R108 had communication concerns that were not addressed on the care plan. The deficient practice had the potential for R101 and R108 not to receive needed care and services.Findings include:Review of policy titled, Comprehensive Care Plans revised 3/20/2025 revealed under Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality.Review of the policy titled Oxygen Administration, revised 02/01/2024, revealed under Policy: Oxygen 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. Under Policy Explanation and Compliance Guidelines: . 4. The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to: a. The type of oxygen delivery system. b. When to administer, such as continuous or intermittent and/or when to discontinue. c. Equipment setting for the prescribed flow rates. d. Monitoring of SpO2 (oxygen saturation) levels and/or vital signs, as ordered. e. Monitoring for complications associated with the use of oxygen.Review of the electronic medical record (EMR) revealed R101 was admitted to the facility on [DATE] with pertinent diagnoses including, but not limited to, hypertension, respiratory failure, generalized anxiety, and seizures.Review of R101's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 10, which indicates R101 has moderate cognitive impairment. Section GG, Functional Status, revealed R101 required setup/cleanup assistance with eating and oral hygiene, moderate assistance with personal hygiene, and maximal assistance with all other ADLs (activities of daily living) and with mobility. Section I, Active Diagnosis, revealed respiratory failure. Section J, Health Problems, revealed shortness of breath when lying flat. Section O, Special Treatments, Procedures, and Programs, did not include that resident is receiving oxygen.Review of R101's care plan initiated on 01/24/2026 with last review history dated 03/31/2026 did not indicate any respiratory issues although the resident is on oxygen and receiving nebulizer treatments.Review of the Physician's Orders for R 101 included but was not limited to:Order dated for 02/04/2026 Pulmicort Suspension 0.5 MG/2ML (milligrams per milliliter) (Budesonide)2 ml inhale orally via nebulizer every 12 hours for SOB (shortness of breath) Supplementary Documentation Codes: Pre and Post Tx (treatment) Lung Sounds C = Clear O = Other (see progress note) Pre and Post Tx - P (pulse), R (respirations) and O2 (oxygen) Sat (saturation) results MNS - Enter the number of minutes of nurse time for the administration.Order dated 03/19/2026, BusPIRone HCl Tablet 5 MG, Give 1 tablet by mouth two times a day for anxietyObservation and interview on 05/06/2026 at 3:57 PM with Registered Nurse (RN) II while standing in room [ROOM NUMBER] confirmed that R101 was receiving oxygen at 3 LPM (liters per minute). RN II confirmed that the resident did not have an order for oxygen. RN II stated that the doctor's order would tell you how much oxygen to give. RN II confirmed that the resident was on oxygen continuously.Interview on 05/06/2026 at 4:08 PM with the Director of Nursing (DON) revealed expectations were when a resident was on oxygen that an order was placed in the system and that the care plan should include oxygen.An interview on 05/06/2026 at 4:10 PM with the Administrator revealed that if a resident was on oxygen, it should be on the care plan. Review of the EMR revealed R108 was admitted to the facility on [DATE] with pertinent (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diagnoses including, but not limited to, encephalopathy, muscle wasting and atrophy, and cerebral infarction. Review of R108's admission MDS assessment dated [DATE] revealed a BIMS score of 6, which indicates R108 has severe cognitive impairment. Section GG, Functional Status, revealed R108 required/was independent/minimum/extensive assistance for ADLs with one/two or more-person assistance.Review of R108's care plan did not indicate that the resident had communication needs.Observation on 05/04/2026 at 2:14 PM revealed when Certified Nursing Assistant (CNA) NN was asked how she communicated with R108, she stated that he didn't talk much but he understood. CNA NN also pointed to and stated that they have a communication line if needed. Observation on 05/05/2026 at 1:45 PM with CNA FF revealed R108 spoke Vietnamese and that he could say some words in English.Interview on 05/06/2026 at 3:21 PM with the Social Worker (SW) revealed that communication should be on R108's care plan.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, record review, and review of the facility's policy titled, Activities of Daily Living (ADLs), the facility failed to ensure ADL care related to nail grooming was provided for four of eight sampled residents (R) (R44, R77, R124, and R144). This failure had the potential to cause the affected residents to harbor bacteria, increasing the risk of physical injury and the spread of infection, as well as causing them to feel self-conscious of their appearance.Findings include:Review of the policy titled Activities of Daily Living (ADLs), revised 3/20/2025 revealed, The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care; 2. Transfer and ambulation. 3. Toileting. 4. Eating to include meals and snacks; and 5. Using speech, language or other functional communication systems. Further review of the policy revealed, .4. a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.1. A review of the facility's admitting records revealed that R44 was admitted to the facility on [DATE] with diagnoses that include, but are not limited to muscle weakness, unspecified lack of coordination, unspecified dementia, and behavioral disturbances.A review of R44's Quarterly Minimum Data Set (MDS) for R44 dated 04/27/2026, revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. Section B revealed the resident makes himself understood and he has the ability to understand others. Section E (Behavior) revealed no documentation indicating rejection of ADL care during the lookback period. Section GG (Functional Abilities and Goals) documented that R44 requires partial to moderate assistance with personal hygiene ADLs.A review of the Care Plan for R44 revealed a focus area of .at risk for an ADL self-care deficit due to his diagnosis. The goal stated that R44 will appear clean, well-groomed and dressed.During an observation and interview on 05/04/2026 at 12:45 PM, R44 was observed in bed with fingernails that were long, jagged, and with visible dark black/brown debris (dirty). R44 stated, I would trim them myself if I could. They don't usually do it for me.Subsequent observations and interviews on 05/05/2026 at 12:15 PM and 05/06/2026 at 9:35 AM revealed that the condition of the resident's nails remained unchanged: they were excessively long and jagged, with visible dark debris (dirty). R44 stated he would allow the staff to provide nail care and does not recall the last time he had his nails groomed.Review of R44's ADL Certified Nursing Assistant (CNA) task sheets for April 04/24/2026 through 05/07/2026 revealed no documentation of resident refusal for personal hygiene. Further review of the record revealed documentation of daily finger pulse oximetry oxygen (O2) saturation assessments.During an observation and interview on 05/06/2026 at 9:40 AM, CNA AA revealed that for residents with diabetes, staff report nail care needs to the nurse; otherwise, CNAs trim nails during showers if the resident allows. She confirmed that R44's nails were long, jagged, and dirty with an accumulation of a dark brown/black substance.2. A review of the facility's admitting records revealed that R77 was admitted to the facility on [DATE] with diagnoses that include but are not limited to unspecified cerebrovascular disease affecting left non-dominant side, contracture left wrist, other reduced mobility, muscle wasting and atrophy, and unspecified lack of coordination.A review of R77's Quarterly MDS dated [DATE], revealed Section C documented a BIMS score of 12, indicating moderate cognitive impairment. Section B revealed the resident makes himself understood, and he has the ability to understand others. Section E revealed no documentation indicating rejection of ADL care during the lookback period. Section GG documented that R77 requires partial to moderate assistance with personal hygiene ADLs.A review of the Care Plan for R77 revealed a focus area of ADL.requires assistance with ADL related to stroke. The goal stated that (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R77 will appear clean, well-groomed and dressed.During an observation and interview on 05/04/2026 at 12:45 PM, R77 was observed in the main dining room with fingernails that were long, jagged, and with visible dark brown/black debris (dirty). R77 stated, They won't do them for me, and I can't do them by myself. The resident states he cannot remember when they were last cleaned and trimmed.Subsequent observations on 05/05/2026 and 05/06/2026 revealed that the condition of the resident's nails remained unchanged: they were excessively long and jagged, with visible dark debris (dirty). R77 stated he would allow staff to provide nail care and does not recall having rejected it in the past. He stated he would like them to be groomed as soon as possible.Review of R77's ADL, CNA task sheets for April 04/23/2026 through 05/06/2026 revealed no documentation of resident refusal for personal hygiene. Further review of the record revealed documentation of daily finger pulse oximetry oxygen (O2) saturation assessments.3. A review of the facility's admitting records revealed that R124 was admitted to the facility on [DATE] with diagnoses that include, but are not limited to, other sequelae of cerebral infarction, unspecified lack of coordination, need for assistance with personal care, muscle weakness (generalized), and other lack of coordinationA review of R124's MDS dated 0 3/17/2026, revealed that Section C documented a BIMS score of 10, indicating moderate cognitive impairment. Section B revealed that the resident makes himself understood, and he has the ability to understand others. Section E revealed no documentation indicating rejection of ADL care during the lookback period. Section GG documented that R124 is dependent on staff for personal hygiene ADLs.A review of the Care Plan for R124 revealed a focus area of ADL.has an ADL self-care deficit due to his overall Disease process.Total assistance with Dressing, Bathing/Showering.Personal Hygiene. The goal stated that R124 will appear clean, well-groomed and dressed.During an observation and interview on 05/04/2026 at 10:45 AM, R124 was observed in bed with excessively long, jagged fingernails and visible dark brown/black debris (dirty). R124 stated that staff generally cared for his needs but could not recall the last time his nails were cleaned and trimmed. He stated that he would like his nails to be groomed.Subsequent observations on 05/05/2026 and 05/06/2026 revealed that the condition of the resident's nails remained unchanged: they were excessively long and jagged, with visible dark debris (dirty). R124 stated he would allow the staff to provide nail care.Review of R124's ADL, CNA task sheets for April 04/22/2026 through 05/05/2026 revealed no documentation of resident refusal for personal hygiene.4. A review of the facility's admitting records revealed that R144 was admitted to the facility on [DATE] with diagnoses that include but are not limited to, need for assistance with personal care, muscle weakness (generalized), quadriplegia unspecified, multiple sclerosis, and cognitive communication deficit.A review of R144's Quarterly MDS dated [DATE], revealed Section C documented a Brief Interview for BIMS score of 10, indicating moderate cognitive impairment. Section B revealed that the resident makes herself understood, and he has the ability to understand others. Section E revealed no documentation indicating rejection of ADL care during the lookback period. Section GG documented that R144 requires substantial assistance with personal hygiene ADLs.A review of the Care Plan for R144 revealed a focus area of ADL. has self-care deficit with ADL r/t (related to) dx (diagnosis) of MS (multiple sclerosis), Wounds and Muscle Weakness. R144 is provided with Total care for Bed Mobility, Transfers with lift and Toileting. Extensive assistance with Dressing, Showering per her preference and Personal Hygiene. The goal stated that R144 will appear clean, well groomed and dressed as per preferences through next review date.During an observation and interview on 05/04/2026 at 10:45 AM, R144 was observed in bed with fingernails that were excessively long, jagged, and with visible dark brown/black debris (dirty). R144 initially stated she could try to trim her nails if the staff would bring her the supplies to do so. She promptly corrected herself and stated, I don't know why I said that. I cannot do them on my own. She stated she cannot clean or trim them and can't remember when they were groomed last. Subsequent observations on 05/05/2026 and 05/06/2026 revealed that the resident's nails remained unchanged: excessively long with remnants of red nail polish.Review of R124's ADL CNA task sheets for April 04/22/2026 through 05/07/2026 (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed no documentation of resident refusal for personal hygiene. Further review of the record revealed documentation of daily finger pulse oximetry oxygen (O2) saturation assessments.During an observation and interview on 05/06/2026 at 9:40 AM, CNA AA stated that a negative outcome could be that the resident scratches himself or herself and could spread germs.During an observation and interview on 05/06/2026 at 9:45 AM, Licensed Practical Nurse (LPN) and Unit Manager (UM) BB stated that CNAs were responsible for cleaning and trimming the nails of non-diabetic residents during showers. Upon observing the nails of R44 and R77, she noted they were excessively long and soiled and stated she would ensure they were cleaned and trimmed immediately. She confirmed the same findings for R144 and R124. She indicated that potential negative outcomes included residents experiencing skin tears and harboring bacteria. Furthermore, she confirmed that because oxygen saturation levels are assessed using a finger pulse oximeter, the condition of the nails should have been observed by staff during those clinical assessments.During an interview on 05/06/2026 at 9:55 AM, the Administrator stated it was her expectation that staff kept residents' nails clean and trimmed. She further stated the potential negative outcomes of this deficient practice included potential skin injuries and infections.During an interview on 05/06/2026 at 10:13 AM, the Director of Nursing (DON) reviewed the nail photos for R44, R77, R124, and R144. She stated the nails should have been trimmed with routine morning ADL care and that the staff would provide the care immediately.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and review of facility's policy titled, Accidents and Supervision, the facility failed to ensure the resident's environment remained free of accident hazards for one of 59 sampled residents (R) (R9). The deficient practice had the potential for chemical hazards being accessible to residents. Findings include: Review of the facility policy titled Accidents and Supervision reviewed date 02/01/2024, documented under Policy: The resident environment will remain as free of accident hazards as is possible. Under Policy Explanation and Compliance Guidelines: 1. Identification of Hazards and Risk.b. The facility should make a reasonable effort to identify the hazards and risk factors for each resident. Review of the electronic medical record (EMR) for R9 revealed admission to the facility on [DATE] with diagnoses that included, but were not limited to dysphagia, oropharyngeal phase, and chronic obstructive pulmonary disease (COPD). Review of R9's most recent Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score was coded as 14, which indicated R9 was cognitively alert and oriented. Review of the care plan for R9, dated 12/08/2025, revealed no documentation for accident hazards. Observation during the initial screening of the facility on 05/04/2026 at 1:26 PM revealed in the room of R9, on top of a two-tier white plastic storage container, was one 16 fl oz (fluid ounce) bottle of 91% (percent) isopropyl alcohol and one 6.2 oz automatic room scent spray. Observation on 05/06/2026 at 10:52 AM revealed one 16 fl oz bottle of 91% isopropyl alcohol and one 6.2 oz automatic room scent spray by R9's bedside. The resident resided in a semi-private room. An interview on 05/06/2026 at 10:57 AM with Licensed Practical Nurse (LPN)/Unit Manager BB verified the presence of one 16 fl oz bottle of 91% isopropyl alcohol and one 6.2 oz automatic room scent spray. LPN BB retrieved the items from R9's bedside and indicated that she had explained the potential accident hazards associated with each item to R9. An interview on 05/06/2026 at 11:05 AM with the Administrator revealed the identified items located in R9's room should not be present in the residents' rooms.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, record review, and review of the facility policies titled Oxygen Administration, the facility failed to obtain a physician order for one of 11 residents (R) (R101) on oxygen. This deficient practice had the potential to cause respiratory distress.Findings include:Review of the policy titled Oxygen Administration, revised 2/1/2024, revealed Oxygen 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. Section titled Policy Explanation and Compliance Guidelines revealed the following:1. Oxygen is administered under orders of a physician, except in the case of an emergency. In such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control. 2. Personnel authorized to initiate oxygen therapy include physicians, RNs, LPNs, and respiratory therapists.Review of the electronic medical record (EMR) revealed resident (R) 101 was admitted to the facility on [DATE] and pertinent diagnoses, including but not limited to respiratory failure and generalized anxiety.Review of R 101 quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 10, which indicates R101 has moderate cognitive impairment. Under Section I, active diagnosis revealed respiratory failure. Section J, health problems, revealed shortness of breath when lying flat. Section O, special treatments, procedures, and programs, did not include that the resident is receiving oxygen.Review of R 101 care plan initiated on 1/24/2026 and revised on 3/31/2026 did not indicate any respiratory issues.Review of the Physician's Orders for R 101 revealed no oxygen orders in the record. Observation and interview on 5/4/2026 at 1:42 pm revealed R 101 is sitting up in bed, eating lunch. She appears weak. She states she is here for rehab. She is receiving oxygen at 3L (liters). She states that she is on continuous oxygen. She also states she returned to the facility on oxygen following her last hospital discharge.5/5/2026 at 12:55 PM R 101 is resting quietly with closed. Oxygen at 2 L per nasal canula. An interview and observation on 5/6/2026 at 3:57 pm with Registered Nurse (RN) II while standing in room [ROOM NUMBER] confirmed that R 101 is receiving oxygen at 3L per min (minute). Surveyor opened the physician orders in R101 Emar (electronic medication administration record), and RN II confirmed that the resident did not have an order for oxygen. RN II states that the doctor's order specifies how much oxygen to give the residents. RN II confirmed that the R101 is continuously on oxygen. She says the tubing is changed once a week. She states that too much oxygen could cause lungs not to receive the maximum oxygen, and if the settings are too low, it could cause a hunger for oxygen, and the residents may begin to use accessory muscles to breathe. An interview on 5/6/2026 at 4:08 pm with the Director of Nursing (DON) revealed that I expect an order to be placed in the system when a resident is on oxygen. If a nurse receives a telephone order for oxygen, she should add the order to the resident's profile. Tubing should be changed weekly. An interview on 5/06/2026 at 4:10 pm with the Administrator revealed that her expectation is that if a resident is on oxygen, the resident should have an order for the oxygen rate. She revealed that hyperoxygenation or hypoxia could be a concern related to a resident receiving oxygen without an order.