

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145671	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Elevate Care South Holland		STREET ADDRESS, CITY, STATE, ZIP CODE 16300 Wausau Street South Holland, IL 60473	

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

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Let each resident or the resident's legal representative access or purchase copies of all the resident's records.</p> <p>Based on record review and interviews the facility failed to provide a resident's medical record to the Power of Attorney (POA)/Healthcare Representative (HCR) in a timely manner after a request was made, for 1 (R11) of 1 resident reviewed for medical records request. Findings include: On 1/22/2026 at 10:50am V5 (Medical Records) stated, I did receive a request in October 2025 from R11's POA. The POA completed an application and submitted Identification. I did need some more documents, and I was unable to reach the POA to inform them of the needed documents. I should have mailed out a certified letter and did not, moving forward I will be sending a certified letter if I'm unable to contact family by phone. On 1/22/2026 at 11:40am V1 (Administrator) said that V5 should have sent a certified letter to the POA for needed documents and moving forward that is the plan. An admission record dated 1/20/2026 indicates R11 had a diagnosis of chronic ischemic heart disease, heart failure renal dialysis, pressure ulcers, a state of Illinois compliant authorization for release of patient information dated 10/1/2025, a request for information on 1/20/2026. Facility Policy: Medical Record Policy Purpose: To ensure that a complete accurate and legal record the resident's care maintained contains justification of diagnoses, treatment results. The record is readily accessible systematically organized to provide a medium of communication among health care professionals involved in the resident's care and to facilitate retrieval and compilation of information. Responsibility: Administrators, Directors of Nursing, Medical records technician. Policy: It is the policy of this facility that an organized, accurate and complete written record will be maintained for each resident in accordance with applicable state and federal guidelines and laws. Standards: The director of nursing/designee with the support of the medical records technician shall assure that medical records are maintained in accordance with the facility/s policies and procedures, and applicable federal and state regulations.</p>

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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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure ongoing revision and updated the resident individualized care plan according to the resident's condition and treatments. This deficiency affects two (R5 and R6) of three residents reviewed for Care plan revision. Findings include: R6 was admitted on [DATE], with diagnoses listed in part but not limited to Alzheimer's disease, Dementia, adult failure to thrive, type 2 diabetes mellitus, chronic ischemic heart disease. Physician active orders: no order for oxygen use. On 1/21/26 at 10:25AM, R6 observed in room laying down, with oxygen in use, at 2L (liters) per nasal cannula, tubing with no label date. On 1/21/26 at 10:44AM, V2 (Director of Nursing) made aware of above findings and said that the oxygen should have a physician's order for administration and tubing should be labeled with date. On 1/21/26 at 1:30PM, V1 (Administrator) made aware of R6 with oxygen in use and no physician order or label on tubing with date, and no care plan for oxygen in use. R5 is a [AGE] year-old with the following diagnosis :chronic respiratory failure with hypoxia, encounter for attention to tracheostomy, dependence on respiratory ventilator status, encounter for attention to gastrostomy, displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing, essential hypertension, other seizures, anxiety disorder, adjustment disorder with depressed mood, major depressive disorder, generalized edema, pain in left hip, diaphragmatic hernia without obstruction or gangrene, delirium due to known physiological condition. R5 Fall Risk scale dated 10/26/25 indicates High risk for falling. The Care Plan dated 2/27/25 documents R5 is at high risk for falls gait/balance problems, poor communication/comprehension, decreased safety awareness, and adverse behaviors: interventions in place include 2/27/25-keep furniture in locked position, 6/20/25 -educate resident to use call light for assistance with toileting and ADL's (Activities of Daily Living), 10/21/25- Bilateral floor mats. 11/29/25-no intervention, 12/1/25-no intervention. On 1/21/26 at 2:00PM, V2 (Director of Nursing) said R5's fall care plan should be updated after each fall with appropriate intervention. On 1/22/26 at 12:00PM, V1 (Administrator) said his expectations are for the care plans to be updated after appropriate interventions are discussed for the residents. Facility Policy Comprehensive Care Plan, revised 11/17/25 Purpose: To develop a comprehensive care plan that directs the care team and incorporates the resident's goals, preferences, and services that are to be furnished to attain or maintain the residents highest practicable physical, mental and psychosocial well-being. Guidelines: the facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the residents rights, that includes measurable objectives and timeframes to meet a residents medical, nursing and mental and psychosocial needs that re identified in the comprehensive assessment.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement fall preventive measures for a resident who is a high fall risk. This deficiency affects one (R5) of three residents reviewed for Fall prevention program. Findings include: R5 is a [AGE] year-old with the following diagnosis :chronic respiratory failure with hypoxia, encounter for attention to tracheostomy, dependence on respiratory ventilator status, encounter for attention to gastrostomy, displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing, essential hypertension, other seizures, anxiety disorder, adjustment disorder with depressed mood, major depressive disorder, generalized edema, pain in left hip, diaphragmatic hernia without obstruction or gangrene, delirium due to known physiological condition. Facility reported incident indicates on 10/21/25 R5 was observed laying on the floor on his left side by facility staff. R5 denied hitting head and level of conscious remained at baseline of Alert and orientated times person, place. R5 reported pain to the left lower extremity. Limb was immobilized and pain medication was administered as ordered by the physician with verbalized relief. Physician notified of the fall and new pain complaint; order received to obtain an x-ray of the left lower leg. X-ray results indicated an acute intertrochanteric fracture of proximal left femur. Physician was updated on the findings and gave further orders to transfer R5 to the hospital for further evaluation and treatment. On 1/20/26 at 1:00PM, R5 observed in room, laying in bed, with one floor mat to the right side of bed, no left side floor mat observed next to R5 bed. On 1/20/26 at 1:00PM, V16 (Assistant Director of Nursing) said that she moved the floor mat on the left side of bed to place the bedside table so that R5 can eat lunch. V16 said she will come back to room once he is done eating. On 1/20/26 at 2:42PM, V2 (Director of Nursing) made aware that V16 removed floor mat to left side of bed for R5 who was in bed, eating lunch, and left in room unsupervised. V2 said that R5 should be up from bed and in wheelchair placed in high visible areas to be monitored, because he is a high fall risk. R5's Fall Risk scale dated 10/26/25 indicates High risk for falling. The Care Plan dated 2/27/25 documents R5 is at high risk for falls gait/balance problems, poor communication/comprehension, decreased safety awareness, and adverse behaviors: interventions in place include 2/27/25-keep furniture in locked position, 6/20/25 -educate resident to use call light for assistance with toileting and ADL's, 10/21/25- Bilateral floor mats. 11/29/25-no intervention, 12/1/25-no intervention. Facility Policy on Fall Prevention Program, revised 11-21-17 Purpose: To ensure the safety of all residents in the facility, when possible. The program will measure which determine the individuals need of each resident by assessing the risk for falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Quality Assurance Programs will monitor the program to assure ongoing effectiveness. Guidelines:-use and implementation of professional standards of practice-communication with direct care staff members-Care plan incorporates: Address each fall Interventions are changed with each fall as appropriate Standards:-Safety interventions will be implemented for each resident identified at risk. Fall/safety interventions may include but are not limited to:-the bed will be maintained in a position appropriate for resident transfers.-Nursing personnel will be informed of residents who are at risk of falling. The fall risk interventions will be identified on the care plan.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>Based on observation, interview and record review the facility failed to ensure that a feeding tube was administered as ordered for one resident (R8) reviewed for tube feedings. Findings include: On 1/20/2026 at 12:33pm R8 said I have a tube feeding and I do not want it on when I'm eating, the nurse has not started my tube feeding at all today. On 1/20/2026 at 2:15pm V2 said I expect for all tube feedings to be administered as ordered or the nurse practitioner notified to adjust the feeding to the resident preference. On 1/21/2026 at 10:12am V10 said R8 does refuse his feeding during his meals, I do expect the feeding to be administered when he is not having his meals by mouth. An admission record dated 1/2-0/2026 indicates that R8 has a diagnosis of Chronic Respiratory Failure, tracheostomy, liver transplant, gastrointestinal placement, seizures, an order summary report for Enteral feed order dated 11/15/2025 for Nepro 1.8 rate of 45 milliliter's an hour for 24 hours total volume 1,080 ml. A care plan dated 11/15/2025 intervention to administer tube feeding as ordered. Facility Policy: Enteral Nutrition (EN)-Tube Feeding Guideline: Enteral Nutrition (EN) may be instituted for individuals who have an intact gastrointestinal tract but are unable or unwilling to take food by mouth in amounts that will support adequate nutrition. Such as individuals with neurological disorders (strokes, head and neck trauma or surgery), cancer and individuals with difficulty swallowing or ingesting adequate amounts of food, and gastrointestinal obstructions. Nursing staff will follow the community enteral nutrition policies and guidelines. Administration of Enteral Formula Continuous drip: Requires a pump and is appropriate for individuals who do not tolerate larger volumes of tube feeding (TF) infusions. 8. Close monitoring of the tube feeding tolerance, intake and output records, nursing notations on physical assessment. 11. Enteral feeding schedule suggests steps in determining an enteral feeding schedule. 13. Monitoring of the individual's actual intake and tolerance of tube feeding is important to ensure that nutritional goals are met and maintained. Monitoring the individuals with tube feeding is an interdisciplinary team effort and includes. A. EN is being delivered as ordered by the physician</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to follow physician's order for oxygen administration affecting one (R6) of three residents reviewed for oxygen administration. Findings include: R6 was admitted on [DATE], with diagnoses listed in part but not limited to Alzheimer's disease, Dementia, adult failure to thrive, type 2 diabetes mellitus, chronic ischemic heart disease. Physician active orders: no order for oxygen use. On 1/21/26 at 10:25AM, R6 observed in room laying down, with oxygen in use, at 2L per nasal cannula, tubing with no label date. On 1/21/26 at 10:25AM, V3 (Wound Care Coordinator) said that the oxygen tubing should have a label with the date to indicate when it was changed to make sure it is clean and for infection control purposes. On 1/21/26 at 10:44AM, V2 (Director of Nursing) made aware of above findings and said that the oxygen should have a physician's order for administration and tubing should be labeled with date. On 1/21/26 at 1:30PM, V1 (Administrator) made aware of R6 with oxygen in use and no physician order or label on tubing with date, and no care plan for oxygen in use. Facility Policy on Oxygen Therapy- last revised 12/1/2021. Purpose: to deliver oxygen in condition in which insufficient oxygen is carried by the blood to the tissues. Indications for oxygen use via supplemental oxygen delivery devices include:-reverse the effects and symptoms of hypoxia-decrease respiratory and cardiovascular workload. Policy/It is the policy of this facility that oxygen shall be used in a safe and effective manner in accordance with applicable rules and regulations and the standard of care. Procedure:Physician order/Verify physician order. 11. Set- up and administration of oxygenE. Discard disposable mask, cannulas, and tubing after use in accordance with equipment change schedule.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that medications were administered as ordered by a physician, for two (R5 and R8) of two residents reviewed for medication administration. Findings include: On 1/20/2026 at 12:33pm R8 said I have not received my morning medications. The nurse said she would give them to me along with my 12:00 noon medications. Its lunchtime and after 12:30pm and I have not gotten them as of now.</p> <p>On 1/20/2026 at 2:15pm V2(Director of Nursing-DON) said I expect the nurses to follow the physician orders and administer medication as prescribed.</p> <p>On 1/20/2026 at 2:30pm V7(Licensed Practical Nurse-LPN) said she was running late this morning and that she had not had a chance to administer his morning medications, V7 said I understand it should be given an hour before and an hour after our start time and I will notify the nurse practitioner and inform her of the medication being administered late.</p> <p>On 1/21/2026 at 10:12am V10(Nurse Practitioner-NP) said R8's medications should be administered as ordered, administering both morning and noon could cause gastrointestinal upset, loose stools and abnormal medications.</p> <p>An admission record dated 1/2-0/2026 indicates that R8 has a diagnosis of Chronic Respiratory Failure, tracheostomy, liver transplant, gastrointestinal placement, seizures, an order summary report for Enteral feed order dated 11/15/2025 for Nepro 1.8 rate of 45 milliliter's an hour for 24 hours total volume 1,080 ml, Keppra 500milligrams two tabs two times daily for seizures, metoprolol 25milligrams two tabs in the morning and at night, tacrolimus 1milligram -3 tabs two times a day for organ rejection. A care plan dated 11/17/2025 to administer medications as ordered.</p> <p>Facility Policy: Medication Administration Effective date 10/25/2014</p> <p>Policy</p> <p>Medications are administered as prescribed in accordance with good nursing principles and practices only by people legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the medication management system in the facility. The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions.</p> <p>B. Administration</p> <p>2. Medications are administered in accordance with written orders of the prescriber.</p> <p>12. Medications are administered within 60 minutes of scheduled time; routine medications are administered according to the established medication administration schedule for the facility.</p> <p>R5 is a [AGE] year-old admitted on [DATE] with the following diagnosis :chronic respiratory failure with hypoxia, encounter for attention to tracheostomy, dependence on respiratory ventilator status, encounter for attention to gastrostomy, displaced intertrochanteric fracture of left femur,</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>subsequent encounter for closed fracture with routine healing, essential hypertension, other seizures, anxiety disorder, adjustment disorder with depressed mood, major depressive disorder, generalized edema, pain in left hip, diaphragmatic hernia without obstruction or gangrene, delirium due to known physiological condition. Order summary report for ferrous sulfate tab 325mg 1 tab in the morning, Valproic acid oral solution 500mg/ml give 10ml by mouth two times a day, clonazepam 2mg tablet give 1 tablet by mouth three times a day. A care plan dated 2/21/25 give medications as ordered.</p> <p>On 1/20/26 at 12:30PM, R5 observed in bed and said he is unsure if he got his medications, usually he does.</p> <p>On 1/20/26 at 2:45PM, V11 (Licensed Practical Nurse) said she is supposed to sign off the medications immediately after administering them, said she doesn't know why she did not do it when she administered them at 9:00am for R5.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement appropriate infection prevention and control practices during wound care observation and oxygen administration. This deficiency affects one (R6) of three residents reviewed for Infection control prevention program. Findings include:R6 was admitted on [DATE], with diagnoses listed in part but not limited to Alzheimer's disease, Dementia, adult failure to thrive, type 2 diabetes mellitus, chronic ischemic heart disease.Active physician order sheet indicated: wound care right buttock-cleanse with ns (Normal Saline), pat dry, cover with hydrocolloid dressing. Wound care sacrum-cleanse with ns/wound cleanser, pat dry, paint betadine, cover with dry dressing every day and prn (as needed). Wound right and left heel-cleanse with ns, pat dry, paint with betadine, cover with dry dressing every day and as needed. Low air loss mattress.On 1/21/26 at 10:20AM, V3 observed during wound care for R6. V3 cleansed sacral wound area and then applied a clean dressing to sacral area, with no hand hygiene in between. V3 also changed dressing to Right foot heel, no hand hygiene in between observed.On 1/21/26 at 10:25AM, R6 observed in room laying down, with oxygen in use, at 2L per nasal cannula, tubing with no label date.On 1/21/26 at 10:25AM, V3 (Wound Care Coordinator) said that the oxygen tubing should have a label with the date to indicate when it was changed to make sure it is clean and for infection control purposes.On 1/21/26 at 10:44AM, V2 (Director of Nursing) made aware of above observations, said that when changing a wound dressing, you always need to perform hand hygiene in between, changes. On 1/21/26 at 10:44AM, V2 (Director of Nursing) made aware of above findings and said that the oxygen should have a physician's order for administration and tubing should be labeled with date. Facility Policy on Oxygen Therapy- last revised 12/1/2021.Purpose: to deliver oxygen in condition in which insufficient oxygen is carried by the blood to the tissues. Indications for oxygen use via supplemental oxygen delivery devices include:-reverse the effects and symptoms of hypoxia-decrease respiratory and cardiovascular workload.PolicyIt is the policy of this facility that oxygen shall be used in a safe and effective manner in accordance with applicable rules and regulations and the standard of care.Procedure:Physician orderVerify physician order.11. Set- up and administration of oxygenE. Discard disposable mask, cannulas, and tubing after use in accordance with equipment change schedule. Facility Policy on Dressing Change-(Clean/Non-Sterile) revised 1/9/18Guidelines:1.prior to beginning treatmenta. check physician order and resident allergies.b. Ensure all equipment supplies are available to perform the dressing change.c. Ensure residents has been assessed for pain and medicated if needed.6. Wash hands7. Prepare/open any necessary supplies and place on top of linen barrier.8. apply gloves. In the event that personal contamination is anticipated, personal protective equipment such as gown or mask should be worn.10. remove soiled dressing and place in plastic trash bag.11. remove soiled gloves and place in plastic trash bag.12. wash hands. Or if hands are not visibly soiled and alcohol-based hand gel may be used to decontaminate the hands.13. apply clean gloves.16. apply prescribed ointment/ or dressing per doctor order.19. initial and date the dressing prior to securing to resident.21. wash hands</p>		