STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146030	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartland Senior Living	101 Trowbridge Road Neoga, IL 62447

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 42702 Based on interview and record review the facility failed to obtain a consent to administer a psychotropic medication for one (R10) of five residents reviewed for psychotropic medications from a total sample list of 33. Findings include: The facility provided Psychotropic Medication Use- Management Policy dated 10/1/2019 documents that consent will be obtained from the resident or resident's representative to administer the psychotropic medication ordered and that consent must be obtained prior to administration of the medication. Additionally, consent in writing will be obtained on the psychotropic medication consent form. A telephone order may be obtained and recorded and then the consent form will be printed and forwarded for signature. R10's physician order dated 4/26/24 documents an order for Seratraline (Antidepressant) 75 milligrams (mg) to be administered daily. R10's medical record does not contain a signed consent for Seratraline 75mg, nor Seratraline 100mg. On 6/11/24 at 11:05 AM V2 Director of Nursing stated, I don't have a consents for the 75mg or the 100mg doses of Seratraline that have been ordered. I only have consents for Seratraline 25mg and Seratraline 50mg.

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on interview and record review the facility failed to report an allegation of physical abuse to the Abuse Coordinator for one (R22) resident out of one resident reviewed for abuse in a sample list of 33 residents. Findings include: R22's undated Face Sheet documents R22's medical diagnoses of Non Traumatic Intracerebral Hemorrhage, Diastolic Heart Failure, Paroxysmal Atrial Fibrillation, Hypertension, Unsteady on Feet and Abnormal Posture. R22's Minimum Data Set (MDS) dated [DATE] documents R22 as cognitively intact. This same MDS documents R22 as requiring maximum assistance for transfers using a total body mechanical lift and dependent on staff for dressing, toileting, bed mobility and person hygiene. R22's Care Plan intervention dated 4/12/23 instructs staff to report any signs of abuse to the Abuse Coordinator. On 6/10/24 at 9:46 AM R22 stated (V3) Certified Nurse Aide (CNA) pushed me around this morning. (V3) throws me around like a sack of potatoes. (V3) pushed me so hard one day she left bruises on my Right Arm. I didn't know who to report it to but I told (V4) Certified Nurse Aide. (V4) told me (V3) has been rough with other people too. I know I have told other people too but I don't remember who. (V4) CNA told me who to report it to but I never saw them. They (facility) didn't do anything with (V3) CNA. (V3) CNA gets me up every morning and slams me around. (V3) doesn't talk to me, she just comes in and pushes me so hard it hurts and then throws me in my chair. (V3) doesn't need to be taking care of people. On 6/10/24 at 12:15 PM V1 Administrator and V2 Director of Nurses (DON) both stated R22's allegation of abuse by (V3) Certified Nurse Aide (CNA) was never reported to V1 nor V2. R22's Initial Incident Report to the State Agency dated 6/10/24 documents R22 (identified as R1 on the report) alleged that V3 Certified Nurse Aide (CNA) pushed her arm leaving fingerprints. On 6/10/24 at 12:26 PM V6 Registered Nurse (RN) stated R22 has Left sided neglect due to a Cerebral Vascular Accident (CVA). V6 RN stated R22 has had several bruises on her Right Upper Arm several times. V6 RN stated I didn't think the bruises were abuse or anything. (R22) gets incidental bruises. I don't report every bruise or do a skin investigation on every little bruise. I never reported anything to (V1) Administrator. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/10/24 at 3:30 PM V4 Certified Nurse Aide (CNA) stated R22 has complained about V3 CNA 'multiple times.' V4 CNA stated (V3) does have a bit of a reputation for being rough. (R22) has told me every time I have worked over there (on R22's hall) or even gone over to help (R22) with something. I have seen bruises on (R22's) Right Upper Arm but I didn't think that was abuse or anything. I never reported them. I didn't ever see (V3) hit (R22) or anything so I thought I had to actually see an abuse to report it. I don't tell my nurse about every little bruise. I didn't tell (V1) Administrator about (R22's) bruises. On 6/11/24 at 12:50 PM V3 Certified Nurse Aide (CNA) stated (V15) Certified Nurse Aide (CNA) and I were helping (R22) a week ago Wednesday (5/29/24) and (R22) said 'you (V3) are mean to me. You hurt me.' We (V3, V15) just thought that is something (R22) says. I didn't report anything to (V1) administrator. (R22) is just like that sometimes. (R22) is alert and oriented but sometimes she says people hurt her when I don't think they do. That is just (R22). V3 CNA stated she should have reported R22's allegation of abuse to V1 Abuse Coordinator/Administrator. The facility policy titled 'Abuse Prevention Program' dated October 2022 documents employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observe, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the Administrator or to a compliance hotline or compliance officer.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 42702 Based on observation, interview and record review the facility failed to provide ordered interventions to prevent the development of deep tissue injuries and worsening of a pressure injury and failed to provide weekly measurements and assessments for pressure injuries for four of five residents (R10, R47, R39 and R53) reviewed for pressure injuries from a total sample list of 33. These failures resulted in R10 and R47 developing deep tissue injuries and R47's unstageable pressure injury worsening. Findings include: The facility provided Prevention of Pressure Ulcers Policy dated August 2008 documents that the purpose of this procedure is to provide information regarding identification of pressure ulcer risk factors and intervention for specific risk factors. When in bed, every attempt should be made to float heels by placing a pillow from knee to ankle or with other devices as recommended by the physician. Additional factors that increase risk of pressure injuries include a healed ulcer. 1.) R10's care plan dated 4/20/22 documents that R10 is at risk for pressure ulcer development due to decreased strength and mobility and that the facility is to ensure that R10 wears heel boots to decrease the potential for pressure injury. The facility weekly pressure ulcer wound report dated April 26, 2024 documents an unstageable, left heel wound resolved for R10. On 6/11/24 at 1:15PM, R10 was observed laying in bed, without heel protectors or any type mechanism to float R10's heels. On 6/11/24 at 1:17PM, V2 Director of Nursing said that R10's right heel is boggy, and is developing a new deep tissue injury. On 6/12/24 at 8:30AM, V2 Director of Nursing said that R10 was supposed to have heel protectors on while in bed because she had a history of deep tissue injuries. On 6/12/24 at 8:45AM, V39 Licensed Practical Nurse said that the likely reason for R10's deep tissue wound is because her heels aren't being protected. I've seen her in bed a couple of times without her heel protectors on. On 6/12/24 at 8:50AM, V15 Certified Nursing Assistant stated, Yesterday (R10) didn't have her heel protectors on and she should have had them on. 2.) R47's physician orders dated 4/24/24 document an unstageable left heel pressure injury. R47's physician orders dated 9/30/23 document to ensure that heel protector boots are on while in bed. On 6/11/24 at 2:00PM, R47 was laying in bed without wearing protective heel coverings. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 6/12/24 at 8:30AM, R47 was sitting in her chair wearing non-slip socks, resting on the floor. R47's left foot had a scab on it and R47's right heel was turning light purple and was boggy, as with a deep tissue injury. The Weekly Wound Report dated 5/20/24 documents R47's left heel unstageable injury measures 0.2 centimeters (cm) x 0.7 cm x 0.4 cm. The Weekly Wound Report dated 5/27/24 documents R47's left heel unstageable injury measures 0.5cm x 1 cm x 0.7 cm and declining. The Weekly Wound Report dated 6/3/24 documents R47's left heel unstageable injury is measured at 0.7cm. No other measurements were taken, nor evaluation of the wound made. On 6/12/24 at 9:00AM, V2 Director of Nursing said that he was unaware of a new deep tissue injury on R47's right foot and that as his wound nurse had left the facility, he was trying to fill in as best that he could. On 6/12/24 at 8:45AM, V39 Licensed Practical Nurse said that the likely reason for R47's deep tissue wound is because her heels aren't being protected. I've seen her in bed a couple of times without her heel protectors on. On 6/12/24 at 12:22PM, V24 Nurse Practitioner said that if the interventions aren't put into place such as the heel protectors, the wounds will continue to worsen and I would expect both (R10 and R47) to be wearing (heel protectors) in bed as well as being monitored weekly. 32853 3.) R53's electronic medical record documents diagnoses including Congestive Heart Failure, Acute and Chronic Respiratory Failure. R53's Physician's Orders dated 6/12/24 document orders for a Stage 3 pressure to the Sacrum, cleanse with wound cleanser, pat dry, apply a hydrocolloid wound dressing and cover with a bordered foam dressing. R53's Skin and Wound Evaluation dated 4/22/24 documents a new area to the Sacrum measuring 2.9 cm (centimeters) x (by) 3.5 cm x 1.3 cm and is documented as MASD (Moisture Associated Skin Damage) due to Incontinence Associated Dermatitis. R53's medical record has no further measurements or assessments of the area to the Sacrum until 5/2/24. R53's Skin and Wound Evaluation dated 5/2/24 documents a Stage 3 pressure wound to the Sacrum with no measurements of the area. The next Skin and Wound Evaluation is dated 5/17/24, 15 days later, and the area is documented as an Unstageable pressure wound to the Sacrum measuring 1.8 cm x 4.9 cm x 2.9 cm. R53's medical record documents two Skin and Wound Evaluations dated 5/23/24 for the pressure wound on the Sacrum. One assessment documents measurements of 5.7 cm x 4.5 cm x 1.8 cm and the other Skin and Wound Evaluation dated 5/23/24 documents measurements of the wound on the Sacrum as 2.0 cm x 2.7 cm x 1.1 cm. There is no explanation as to why there are two different assessments of the same area for R53 on 5/23/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R53's Skin and Wound Evaluation dated 5/30/24 does not have any measurements of the pressure wound on the Sacrum. The next measurements for R53's pressure wound on the Sacrum are 14 days later on 6/6/24. R53's Skin and Wound Evaluation dated 6/6/24 documents measurements of the pressure wound on the Sacrum as 0.9 cm x 1.5 cm x 0.8 cm. On 6/12/24 at 11:25 AM, V2 Director of Nursing confirmed there were missing weekly assessments and could not explain why they were missing. V2 stated that their wound nurse is no longer with them. V2 stated that the wound logs that he has, document on 5/4/24 and on 5/30/24 that the nurse was unable to measure the wound but V2 stated there is no documented reason as to why they were not able to get measurements of the pressure wound on R53's Sacrum on those dates. On 6/12/24 at 11:55 AM, V29 Licensed Practical Nurse completed a wound treatment on R53's pressure wound to the Sacrum. The area was bright red and approximately 1 cm around. R53 was laying in bed on a low air loss mattress with a pillow under her right hip and the head of the bed elevated slightly. 4.) R39's Care Plan dated 4/23/24 documents diagnoses including Type 2 Diabetes Mellitus with Diabetic Neuropathy and Nutritional Deficiency. R39's Skin and Wound Evaluation dated 4/30/24 documents measurements of an unidentified wound as 0.3 cm x 0.9 cm x 0.5 cm. This wound assessment does not document what type of wound it is or where the wound is located or any other assessment of the wound. R39's Treatment Administration Record (TAR) dated 5/1/24 through 5/30/24 documents an order for a Stage 2 wound to the Coccyx and to cleanse with wound cleanser, pat dry, apply a hydrocolloid wound dressing and cover with a bordered foam dressing once a day every three days for wound management with a start date of 5/2/24. R39's medical record does not document any other wound assessments or measurements of the area on the Coccyx. On 6/10/24 at 10:02 AM, R39 was in her room in her recliner with her feet elevated. R39 stated that she has a wound on her bottom and has an extra cushion in her recliner. On 6/10/24 at 10:11 AM, V29 Licensed Practical Nurse stated that R39 has a pressure ulcer on her Coccyx. On 6/12/24 at 11:25 AM, V2 Director of Nursing confirmed there were no other measurements besides the ones on 4/30/24 for R39's wound on her Coccyx.

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F 0689 Level of Harm - 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** 42702 Based on observation, interview and record review the facility failed to prevent injuries from multiple mechanical lift transfers (R10) and failed to supervise a dementia resident to prevent an elopement (R56) for two of two of residents reviewed for accidents from a total sample list of 33 residents. Failing to safely transfer R10 using the mechanical lift resulted in R10 suffering skin tears to bilateral legs. Findings include: 1.) On 6/11/24 at 1:15PM, R10's bilateral shins have open areas, with dried, blood soaked dressings approximately the size of a knee cap covering the tears. The facility skin and wound evaluation dated 4/24/24 documents a new skin tear on R10's right front shin. No new interventions were documented in the medical record after this skin tear occurred. The facility risk evaluation dated 5/3/24 documents a new skin tear on R10's left shin caused by the mechanical lift hitting R10's legs. The facility weekly wound report-non pressure dated 5/27/24 documents a left shin skin tear and nothing about a right shin skin tear. On 6/12/24 at 8:20AM, V2 Director Of Nursing said that the cause of R10's skin tears on her shins was from the mechanical lift hitting her legs during transfer. We wrapped the mechanical lift to prevent it from happening again. 41970 2.) R56's undated Face Sheet documents R56's medical diagnoses as Dementia, Cognitive Communication Deficit, Senile Degeneration of Brain and history of falls. R56's Minimum Data Set (MDS) dated [DATE] documents R56 as severely cognitively impaired. This same MDS documents R56 as requiring maximum assistance for bed mobility, transfers, toileting, bathing, dressing and transfers. R56's Initial Report to the State Agency dated 6/10/24 documents (R56) was witnessed by (V7) Medical Records sitting out the back door by (V20's) Visitor's car. (V20) had propped the back door open to unload a piece of furniture. On 6/10/24 at 3:21 PM R56 was sitting in a wheelchair in the loading area beyond the facility sidewalk next to V20's car. R56 had removed her own foot pedals and was holding them in her lap. R56 was sitting next to V20's back passenger car door. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 6/10/24 at 3:20 PM V20 (R14) visitor reported that R56 had followed him out of the facility and into the parking lot waiting for a ride home. V20 stated he had paused the alarm on the back sliding doors so that he could bring items in and out of facility for R14. V20 stated (R56) must have followed me out. She said she is waiting for a ride home. I don't think I am supposed to do that. I don't think (R56) should be loose. On 6/10/24 at 3:30 PM V1 Administrator stated V20 (R14's) visitor held the back sliding doors open which allowed R56 to wheel herself out of the facility unnoticed. V1 stated either way the staff should have been watching more closely. V1 stated R56 has little safety awareness and she should not be out of the facility unattended. V1 Administrator stated the facility policy on Elopements only covers what to do after someone is found to be missing. V1 stated the facility does not have a separate policy to instruct staff to monitor residents. V1 Administrator stated That is just standard of care. Our staff should know to supervise residents when a door is left open.

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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. 37813 Based on observation, interview, and record review the facility failed to maintain a urinary catheter in a safe, sanitary, and dignified manner for one resident (R38) of four residents reviewed for catheters in a sample list of 33. Findings include: The facility's policy Catheter Care Urinary revised September 2005 states The purpose of this procedure is to prevent Urinary Tract Infections. This policy also states Be sure the catheter tubing and drainage bags are kept off the floor. The policy also states The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. The policy also states Ensure the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (note: catheter tubing should be strapped to the resident's inner thigh.) R38's Care Plan revised 6/12/24 includes the following diagnoses: Chronic Kidney Disease Stage 3B, Benign Prostatic Hypertrophy with Lower Urinary Tract Symptoms. On 6/10/24 at 12:00PM R38 was observed sitting in the hall with the catheter tubing dragging on the floor. The catheter bag was hanging under the wheelchair and was not contained in a dignity bag. On 06/12/24 at 2:05 PM V26, Certified Nurse's Aide (CNA) and V28, Certified Nurse's Aide (CNA) were providing catheter care for R38. When transferring R38 to bed per sling type mechanical lift V26 lifted the catheter bag to the level of R38's chest and urine was noted to back flow into the catheter tubing. V26 stated V26 was not aware the drainage bag should be kept below the level of the bladder. R38's catheter was not anchored to prevent torsion on the tubing. R38 stated When you pull on the tube it hurts. Redness was observed around R38's urinary meatus. R38's Medication Administration Record (MAR) for June 2024 includes a physician's order for Macrobid (antibiotic) Oral Capsule Give 100 mg by mouth one time a day for recurrent UTI (Urinary Tract Infection). On 6/12/24 at 12:30PM V2, Director of Nursing stated The catheter bag should not be above the level of the bladder. We do usually use an anchor device. (R38) likes to pull on his catheter and has pulled it out in the past.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 42702 Based on observation, interview and record review the facility failed to properly administer intravenous medication to prevent infection for one (R316) of one residents reviewed for intravenous medication administration from a total sample list of 33 residents. Findings Include: The facility Medication Administration, Intravenous Administration of Fluids and Electrolytes documents that staff will be knowledgeable regarding the safe and aseptic administration of intravenous fluids and electrolytes for hydration. Prime tubing of administration set, disinfect needleless connection device with alcohol wipe, flush catheter using normal saline per facility protocol, connect primed administration set to needleless connection device, and then open roller clamp. R316's diagnosis list includes: Cellulitis of left finger, Diabetes Mellitus Type Two, Rhabdomylosis, Insomnia, Depression, Hypertension and Joint Pain. R316's physician orders dated 6/11/24 document an order for Vancomycin (antibiotic) 1 gram (gm) to be given intravenously, daily for five days. On 6/12/24 at 9:10AM, V23 Licensed Practical Nurse (LPN) administered Vancomycin 1gm per intravenous line. V23 LPN unscrewed the needleless cap from end of the intravenous catheter opening the catheter line to air. V23 LPN then used an alcohol swab on and inside the open end of the intravenous catheter and then flushed the catheter with normal saline. V23 LPN then allowed the open catheter to drip blood on the floor while she primed an unknown amount of Vancomycin through the tubing and into the waste basket. V23 LPN then connected the Vancomycin line directly into the open port. On 6/12/24 at 10:00AM, V2 Director of Nursing said that he went over intravenous administration with V23 LPN the other day and showed her to leave the cap on and not open the system. She needs more training on (intravenous lines). I would expect the system to remain intact and she should not have wiped the open catheter with alcohol. Managing R316's intravenous line the way that V23 LPN could cause R316 an infection.

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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** 50322 Based on observation, interview and record review the facility failed to ensure a resident had an order for the use of oxygen and failed to ensure oxygen/nebulizer tubing/equipment was changed according to facility policy for two of three residents (R265 and R266) reviewed for respiratory care in a sample list of 33 residents. Findings include: The facility's Oxygen policy with effective date of 1/1/2015 states that tubing must be changed weekly and must be labeled with date and initials of individual who changed the tubing. The facility's undated Nebulizer policy documents nebulizer tubing and mask or t-tube (T shaped tube) device must be changed every 24 hours and rinsed post treatment. 1.) On 6/11/24 at 10:42 AM, R265 was in R265's room and there was an oxygen concentrator in the room. The hydration bottle on the concentrator and the oxygen tubing were not dated to indicate when they were changed. R265's Medication Administration Record and Treatment Administration Record dated 6/11/24 do not document an order for oxygen or an order for tubing changes for the oxygen or for the nebulizer. R265's Order Summary Report dated 6/11/24 does not document any orders for oxygen administration, oxygen tubing changes or nebulizer mask and tubing changes. This Order Summary documents an order for Albuterol Sulfate Inhalation Nebulization Solution 2.5 MG (milligrams)/3ML (milliliters) 0.083% one vial, inhale orally via nebulizer every 4 hours as needed for Wheezing or SOB (Shortness of Breath) with a start date of 6/7/24. R265's Care Plan with an admitted [DATE] does not document the use of nebulizer treatments or oxygen therapy. R265's Nurse's Note dated 6/11/24 at 9:59 AM documents R265 continues to use oxygen via nasal cannula. On 6/11/24 at 11:15 AM, V2 Director of Nursing confirmed there was no active order for R265's oxygen administration. V2 stated he personally brought R265 to the facility and R265 was on room air, not oxygen, at that time. 2.) On 6/11/24 at 12:09 PM, R266 was in R266's room sitting in the recliner with the nebulizer machine sitting on windowsill. The tubing and the mask were attached to the nebulizer machine and were laying open on top of a clear bag. The Nebulizer mask and tubing did not have the date on them to indicate when they were changed. R266 stated he had used the nebulizer at least three times that day. On 6/12/24 at 9:55 AM, V2 stated all tubing is changed on Saturday nights and that task is documented on the resident's Treatment Administration Record. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146030	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartland Senior Living	101 Trowbridge Road Neoga, IL 62447

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	R266's Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated 6/10/24 does not document an order for nebulizer tubing or mask changes. R266's MAR/TAR documents an order for Ipratropium Bromide Inhalation Solution 0.02% (percent) 2.5ml (milliliters) inhale orally via nebulizer three times a day for Pneumonia for 10 days with a start date of 6/4/24 and an order for Levalbuterol HCL (Hydrochloride) Inhalation Nebulizer Solution 0.63mg(milligrams)/3ml; 3ml inhale orally via nebulizer three times a day for Pneumonia for 10 days with a start date of 6/4/24. R266's Order Summary Report dated 6/11/24 does not document an order to change the nebulizer tubing or the nebulizer mask.