STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165191	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan - Red Oak	201 Alix Avenue Red Oak, IA 51566

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident interviews, family interviews, staff interviews, hospital document review and provider interview, the facility failed to provide quality nursing care by not completing an assessment or intervention when a resident had low oxygen saturation (Resident #16) and for a resident who was coughing/spitting up blood (Resident #41) for 2 of 3 residents reviewed. The facility reported a census of 34 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE] documented Resident #16 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. The MDS documented Resident #16 had diagnoses of chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), obstructive sleep apnea, anxiety, paroxysmal atrial fibrillation and sleep related hypoventilation in conditions classified elsewhere. The Care Plan dated 12/8/25 for Resident #16 documented the resident has altered respiratory status related to sleep apnea, diagnosis of hypoxic respiratory failure and COPD. The care plan directed staff to monitor for signs and symptoms (s/s) of respiratory distress and report to her provider as needed: increased respirations, decreased pulse oximetry, increased heart rate, restlessness, diaphoresis, headaches, lethargy, confusion. Review of Resident #16's April 2026 Medication Administration Records - Treatment Administration Records (MAR-TAR) documented physician's orders for albuterol sulfate nebulization solution 2.5mg / 3mL give one dose inhaled orally via nebulizer every 24 hours as needed for dyspnea document oxygen saturation, pulse, respirations and lung sounds pre and post administration, albuterol-budesonide inhalation aerosol 2 puff inhaled orally every 6 hours as needed for wheezing and oxygen at 2LPM per nasal cannula via oxygen concentrator or tank to maintain saturation above 92% every shift for shortness of breath. Review of Resident #16's April 2026 MAR-TAR lacked documentation as needed albuterol sulfate nebulization solution or albuterol-budesonide inhalation aerosol were administered. Review of Resident #16's electronic health record (EHR) titled, Progress Notes documented the following: On 4/15/26 at 10:50 AM a call was placed to Resident #16's primary care physician's nurse regarding residents' oxygen saturation. Left a message with a call back number. On 4/15/26 at 12:04 PM, a return call from Resident #16's primary care physician's (PCP) nurse regarding Resident #16 unsure of what could be going on. Notified that vitals are stable and oxygen saturation was fine at that time that resident was laying down with BiPAP on. PCP was notified to see if he can stop and see the resident tomorrow. (continued on next page)

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

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 4/15/26 at 10:41 PM Resident #16 called 911 thinking she was at another place of residence and the person beside her had a stroke. 911 called the facility saying she called them and 2 ambulance employees arrived at the facility. Resident #16 was taken to the hospital. Husband was notified. DON was notified. On 4/16/26 at 1:06 AM, the hospital was called in reference to Resident #16 for an update. The resident had an exacerbation of CHF. The resident was being transferred to another hospital for care. The Progress Notes for Resident #16 lacked documentation of a comprehensive respiratory assessment on 4/15/26. Review of Resident #16's EHR titled, Oxygen Saturation Summary documented on 4/15/26 at 4:29 AM Resident #16 had an oxygen saturation of 96% on room air, on 4/15/26 at 8:11 AM Resident #16 had an oxygen saturation of 90% on BiPAP, on 4/15/26 at 10:55 AM Resident #16 had an oxygen saturation of 93% on BiPAP and on 4/15/26 at 7:32 AM Resident #16 had an oxygen saturation of 93% on BiPAP. Review of Resident #16's EHR dated 4/15/26 titled, Assessments documented the only assessments completed on 4/15/26 were weekly skin assessment and infection assessment. Neither assessment documented a respiratory assessment. Review of Resident #16's document dated on 4/15/26 at 10:04 PM titled, Prehospital Care Report documented Fire Department was initially dispatched to Resident #16's previous residence for a report of a female possibly experiencing a stroke. Unit 115 responded emergent and arrived on scene without incident or delay. Upon arrival, EMS personnel knocked on multiple apartment doors and announced their presence; however, no residents reported calling 911. Dispatch then updated EMS that Resident #16 was located at the current skilled nursing facility. Unit 115 responded to the facility and arrived without delay. Upon arrival at the skilled nursing facility, EMS attempted entry. Staff members were visible at the nursing station observing the entrance. EMS knocked, and staff opened the door. When questioned about the situation, one staff member stated, I don't know, I just got here, and later added, Well, she's been like this all day. EMS requested staff to direct them to the patient. As EMS approached the patient's room, audible screams for help were heard. A housekeeping staff member was observed entering the room asking if everything was okay. EMS entered shortly after. The patient was found lying supine in a bed, alert enough to visually track EMS personnel upon entry. The patient appeared pale and cool to the touch, with an altered mental status. The patient expressed confusion and stated concern about a lady that fell in the corner, the patient was informed there was no one else there. EMS and nursing staff briefly stepped into the hallway for clarification. Nursing staff reported the patient had been in this condition throughout the day and were unsure why 911 had been called. Initial vital signs revealed oxygen saturation levels in the high 60s to low 70s. The patient consented to transport. The patient was transferred to the EMS stretcher, secured, and moved to the ambulance. Once inside, a full set of vital signs was obtained, including blood pressure. CPAP was initiated with high-flow oxygen at 5 cm H2O PEEP. Due to continued respiratory distress and minimal improvement in oxygen saturation, PEEP was increased to 7.5 cm H2O, resulting in a slight improvement to 82%. Due to continued shortness of breath, PEEP was further increased to 10 cm H2O. Auscultation of lung sounds revealed rales in the bilateral lower lobes. The patient has a significant medical history including COPD, CHF, and diabetes. Transport to the receiving facility was initiated. The Prehospital Report further documented at 10:27 Resident #16 had a blood pressure of 154/78, a pulse of 101, respirations of 36 and oxygen saturation of 62% on room air. Review of Resident #16's hospital report provided by the facility with a date of 4/16/26 documented (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Resident #16 was transferred to the hospital for possible pneumonia, possible CHF exacerbation, rales and rhonchi bilaterally. Chest x-ray showed possible pneumonia. Resident #16 was hallucinating but was alert and oriented x 3. Resident #16 explained she was at the emergency department (ED) because her breathing felt heavy. Resident #16 explained she has had heavy breathing for about a week. Resident #16 stated she was not usually wheezy but had noticed wheezes over the past couple days. Oxygen saturations reported in the 70's at the nursing facility. On 4/20/26 at 2:15 PM Staff Y, Medical Personnel Ambulance Crew stated the 911 call center was notified at 10:03 PM on 4/15/26 and arrived at the facility to Resident #16 at 10:19 PM. Staff Y explained Resident #16 was on her bipap and had low oxygen saturation of 62% on the bipap and respirations of 36. Staff Y said Resident #16 stated she was getting tired of breathing so hard and Staff Y asked if Resident #16 stopped breathing if he could place a tube to help and she said yes. Staff Y stated he had previous interactions with Resident #16 at her house and this was not her normal. Staff Y explained Resident #16 appeared hypoxic as she was confused. Staff Y explained Resident #16 was taken to the in town Emergency Department (ED) and she was then transferred to another hospital ED for a higher level of care than what the original hospital could provide. Staff Y explained she turned Resident #16 onto their oxygen with cpap and ended up going to 5 then 7.5 cm of water then at 10 for Positive End-Expiratory Pressure (PEEP) setting. On 4/21/26 at 3:50 PM Staff G, Registered Nurse (RN) acknowledged she did have interactions with Resident #16. Staff G stated Resident #16 was alert and oriented but before she was sent to the hospital she was hallucinating a little bit. Staff G stated Resident #16's hallucinations were seeing people that were not in the room. Staff G explained Resident #16 was not sent out on her shift. Staff G stated she thought that Resident #16 called 911 herself. Staff G stated Resident #16 was alert and oriented for most of the shift with a couple of hallucinations. Staff G explained when therapy sat Resident #16 up on the side of the bed she could not get enough air. Staff G stated Resident #16's oxygen saturation was checked and it was 68% and at that time she was put back on her bipap. Staff G explained Resident #16 was on the bipap prior to sitting up. Staff G stated therapy was in the room about 10:30 AM on 4/15/26. Staff G stated she was Resident #16's nurse that morning. Staff G explained once the bipap was applied Resident #16's oxygen saturation increased within a couple of minutes. Staff G stated she completed an assessment but did not remember if she documented the assessment. Staff G stated the assessment would probably be in the progress notes. Staff G explained guaifenesin was given because Resident #16 had complaints of a cough. Staff G stated she did not know how long Resident #16 had been complaining of a cough. Staff G stated Staff Z, RN had administered the medication for the cough and stated Resident #16 had been complaining of a cough. Staff G stated she called Resident #16's Primary Care Physician's (PCP) office and spoke with a nurse about the oxygen level. Staff G stated the nurse said to keep monitoring and if it did not seem it was getting better to send her out to the ED. Staff G said the nurse explained for her to utilize breathing treatments and supplemental oxygen as needed. She stated she did not give any breathing treatments because she was fine before she left. Staff G stated she continuously checked her oxygen saturation and listened to her lungs but did not think she charted it. Staff G stated she thought she should have charted the oxygen saturation and lung sounds. Staff G stated Resident #16 was supposed to wear her bipap when she was in bed and the oxygen was on then. Staff G stated at 8:11 AM on 4/15/24 she did not increase the oxygen with the 90% oxygen saturation noted. Staff G stated Resident #16 at 90% was a concern because she typically ran higher. Staff G stated that 90% did prompt her to increase the oxygen to 2.5 L but she did not document it or call the physician for orders. Staff G stated she could have got an order but she would have notified the physician. Staff G stated she did notify the physician for the increase to 2.5L of oxygen on the bipap. Staff G stated at that time she did retake the oxygen and did not document the results. Staff G stated the oxygen level had (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	increased to 94% at that time. Staff G stated Resident #16 was not showing any signs of respiratory distress once on the bipap she was just fine. Staff G stated she stayed in bed that day but that was not abnormal. Staff G said Resident #16's husband was at the nursing home that morning. Staff G explained Resident #16 was not requesting to be sent out of the facility at that time. Staff G stated the physician called back and that was when she was told to monitor. Staff G stated the as needed medication use would be prompted if the oxygen was ineffective. Staff G stated she would transfer to the hospital if she was unable to maintain an appropriate oxygen level with what they had available. Staff G stated she did not show any signs and symptoms she needed to be sent to the hospital that day. On 4/21/26 at 10:35 PM Staff H, Licensed Practical Nurse (LPN) stated she was familiar with Resident #16. Staff H stated she had cared for Resident #16. Staff H said she worked with Resident #16 on the night of 4/15/26. Staff H stated she was called by the ambulance crew that they were coming to the facility because Resident #16 called them. Staff H stated the ambulance crew told her that Resident #16 called and told the ambulance crew someone by her was having a stroke. Staff H stated she had not seen Resident #16 that evening. Staff H stated Staff K was the female nurse that was on duty the shift prior. Staff H explained Staff K, RN never said a word about her or any concerns with Resident #16. Staff H said she had no report there were concerns with Resident #16 earlier that day. Staff H stated if she found a resident with the oxygen saturation under 80% she would complete an assessment. Staff H stated the assessment would consist of the oxygen level, look at antibiotic, stress level, head of bed, and lung sounds. Staff H stated Resident #16 wore a bipap that had oxygen from the concentrator. Staff H stated the ambulance guys entered the room and she removed the bipap when they entered the room. Staff H stated she did not remember what the oxygen level that the ambulance driver obtained. Staff H explained Resident #16 became short of breath the moment she removed the bipap. Staff H stated she had worked with Resident #16 on Sunday. Staff H explained Resident #16 was not ill, short of breath and did not require any as needed medication. Staff H stated she would apply the oxygen and utilize the as needed Albuterol and follow the documentation recommendation. On 4/22/26 at 9:31 AM Staff AA, Physician's clinic nurse stated she told the nurse at the facility a steroid or antibiotics could be started but if further trouble the facility should transfer Resident #16 to the ED. The clinic nurse stated the nurse at the facility never told her that Resident #16 had an oxygen saturation of 68%. The clinic nurse stated the facility staff were having trouble keeping Resident #16's oxygen saturation above the 90's. She stated the facility nurse explained Resident #16's oxygen saturation was only 80's. The clinic nurse stated the facility nurse explained once the bipap was on Resident #16's oxygen saturation was stabilized at 90%. She stated she explained that Resident #16 did have an as needed order for oxygen. The clinic nurse stated when she called the facility back the nurse explained that Resident #16 was stable and using oxygen. She explained if she was notified that Resident #16 had an oxygen saturation of 68% the physician would have probably had said she needed to be evaluated in the ED. The clinic nurse stated Staff G's initial voice mail sounded like she was a little concerned. She stated the supplemental oxygen would be utilized when she was not asleep. She stated she did not think Resident #16 needed to be in bed wearing the bipap all day. The clinic nurse stated when she verified the orders from the nursing home she verified there was as needed oxygen and Staff G was reminded that it could be utilized and it was there for a reason. The clinic nurse stated the as needed oxygen should have been utilized, or the as needed nebulizer treatment, or the hand held inhaler. On 4/22/26 at 10:43 AM Resident #16's husband acknowledged he was at the hospital with Resident #16 at that time and would be returning 4/23/26. Resident #16's husband stated Resident #16 left the (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	faciity on 4/15/23. He explained Resident #16 had pneumonia and it was bad. He stated Resident #16 had pressure on her heart and had to get rid of fluid. Resident #16's husband explained Resident #16 was telling the nurses at the facility on 4/15/26 that she had a fluid overload problem. He stated they gave her compression gloves and arms. Resident #16's husband stated the facility nurses did not seem concerned about it. He stated Resident #16 was telling them that she was not feeling good that day. Resident #16's husband stated they wanted Resident #16 to go to therapy and do 45 minutes worth of therapy. He stated Resident #16 was gasping for air so bad that she was seeing things. Resident #16's husband explained his wife told him the facility staff were not answering her call so she called 911. He stated Resident #16 had felt ill for several days and that she had told staff she felt ill every day. Resident #16's husband stated the nurses really did not do any assessments on his wife during those days. He said he was not at the facility when Resident #16 was transferred to the Emergency Department (ED). Resident #16's husband stated Staff H, Registered Nurse (RN) called him and said Resident #16 was going to the hospital. He explained he was at the facility around 9:30 AM - 10:00 AM and left at around 8 pm on 4/15/26. He stated he did not remember any nurse completing an assessment on his wife the whole day of 4/15/26. He explained the facility nurses did not offer Resident #16 an as needed breathing treatment or increase her oxygen. Resident #16's Husband stated it did appear his wife was struggling to breath and did not have the air to do what they wanted her to do. He stated his wife's oxygen was never checked. Resident #16's husband said Staff D, Certified Nurse Assistant (CNA) and Staff X, Physical Therapy were in the room when his wife was struggling to breathe. He explained that Staff D said let's put her back to bed. Resident #16's husband said Resident #16 was just sitting on the side of the bed and she could not even get out of bed. He stated he did not ask for her to go to the hospital. He stated Resident #16 was hallucinating while he was sitting there in the room. He acknowledged Resident #16 had never had hallucinations prior to that day. Resident #16's husband stated he was worried for his wife but he was not a medical person he relied on the nursing judgement of the nurses at the facility. He stated she had edema in her legs that was so tight that he had to apply lotion because they itched. Resident #16's husband stated Resident #16 had swelling in her hands as well. He stated it was not common for her to have that much swelling. Resident #16's husband stated Staff H told him that his wife was being transferred to the hospital, she was hallucinating and he might want to get up there as soon as he could. On 4/22/26 at 10:43 AM Resident #16 acknowledged she was at the hospital and there were plans for her to return home tomorrow 4/23/26. Resident #16 said she left the faciity on 4/15/26 to the emergency room. Resident #16 said she had pneumonia and it was bad. Resident #16 explained she told the nurses at the facility that she had a fluid overload problem on the day of 4/15/26. Resident #16 said the nursing staff gave her compression gloves and compression sleeves. Resident #16 stated the facility nurses did not seem concerned about it. Resident #16 said she told them she was not feeling good that day. Resident #16 stated the staff wanted her to go to therapy and do 45 minutes of therapy that day. Resident #16 said she could not even get up, she finally told them to stop and her body told her that she cannot do this anymore. Resident #16 said there were 4 of them there and they finally put her back to bed. Resident #16 said she was gasping for air so bad that she was seeing things. Resident #16 said the facility staff were not answering her call light so she called 911. Resident #16 stated she felt ill for several days. Resident #16 stated she had told staff she felt ill every day. Resident #16 explained the nurses at the facility really did not do any assessments when she said she was ill. Resident #16 stated she did not remember the exact oxygen level but it was probably in the 70's because she was seeing things. Resident #16 stated she had so much fluid on her chest that her heart could not beat appropriately. Resident #16 explained on 4/15/26 when she said she could not breath very well the nursing staff did not offer her a breathing treatment or increase her oxygen. Resident #16 stated it felt like she was struggling to breath and gasping for air. Resident #16 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 4/23/26 at 11:28 AM Staff D, Certified Nurse Assistant (CNA) acknowledged he worked with Resident #16 frequently. Staff D explained Resident #16 would have him write a note and hang it on the door because she had a migraine and did not want to do therapy. Staff D stated him and one of the therapy girls tried to get Resident #16 up on 4/15/26. Staff D stated Staff G offered her the portable oxygen tank but she did not want it. Staff D stated before they even stood her up she said you guys are making me do stuff I do not want to do. Staff D stated Resident #16 said she could not breathe and that it was around 10:00 AM or 11:00 AM that day. Staff D stated they laid her back down and she seemed fine. Staff D stated she went to the hospital that evening. Staff D stated other than her insisting she wanted to lay down and saying she was having a difficult time breathing she did not have any other complaints. Staff D stated he did not remember if the vitals were good or bad. Staff D stated he thought that her oxygen was low because she could not breathe well but did not remember the exact number. Staff D stated Resident #16's husband was not in the room at that time. Staff D stated therapy had asked him to help because sometimes they need a second person to help. Staff D explained when Staff G came in Resident #16 said she was having a difficult time breathing. Staff D stated Resident #16 was talking alright. Staff D explained Resident #16 was talking very slowly but seemed really weak and really tired. Staff D stated that time it might be because she could not breathe. Staff D stated she did take long deep breaths between words and that was when Staff G offered her the portable concentrator. Staff D stated he had to do other tasks and was not sure if Staff G completed an assessment he did not see. Staff D explained Resident #16 stayed in bed all day on 4/15/26 and usually does not eat breakfast but usually eats lunch. Staff D said Resident #16 did not eat the day before and did not eat lunch that day. Staff D said Resident #16 stayed in bed 2 days in a row was very unusual. Staff D said she never stayed in bed for 2 days and that was not normal for her. Staff D stated Resident #16 had not had hallucinations in the past except after surgery with anesthesia. Staff D stated she would complain of migraines. Staff D stated Resident #16 had not ever complained about difficulties breathing until that day. On 4/23/26 at 12:42 PM Staff V, Registered Nurse (RN) / Infection Preventionist (IP) stated he had worked the floor as a nurse and had been on the overnight shift for the last 6 months. Staff V explained if a resident had an oxygen saturation of 80% he would ask the resident for subjective data like if it was difficult to breathe or how they felt. Staff V explained he would then obtain vital signs. Staff V stated if the resident's oxygen saturation was lower than 80% the physician would probably want the resident sent to the Emergency Department (ED). Staff V explained he would attempt to utilize an as needed medication if there was an order such as a nebulizer treatment, an inhaler or oxygen. Staff V stated if the resident's oxygen saturation was 70% he would complete all of that in the room and if the resident was coherent he would ask the resident for subjective data. Staff V explained might need to call 911 and get an order from the physician at the same time. Staff V explained a resident could be sent out without a physician order in an emergency. Staff V said a resident with an oxygen saturation of 68 would be an emergency and that resident would have been sent to the ED. Staff V stated even if he was able to get the resident to baseline he would definitely let the physician know the oxygen saturation level of 68 percent because it might change the outcome of what the physician might want done. Staff V explained an oxygen saturation of 68% would indicate more of a potential issue than just low oxygen saturation. 2. Resident #41's Quarterly Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of high blood pressure, pneumonia, chronic obstructive pulmonary disease (COPD), and atrial fibrillation (irregular heart beat). It revealed the resident was independent with eating, required setup assistance with personal hygiene, was dependent with toileting hygiene, bathing, and footwear, and required maximal assistance with all other Activities of Daily Living (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	(ADLs) and mobility. It also revealed he was short of breath with activity and lying flat but not while at rest. It further revealed he received an anticoagulant (blood-thinner) medication during the 7-day look-back period. The Electronic Health Record (EHR) included a physician's active order dated 2/28/25 for apixaban oral tablet 5 MG; 1 tablet by mouth every morning and at bedtime related to atrial fibrillation. The Care Plan revised 1/08/26 included altered respiratory status/difficulty breathing related to COPD and directed staff to monitor for signs and symptoms of respiratory distress and report to the health care provider PRN (as needed): increased respirations, decreased blood-oxygen level, increased heart rate, restlessness, diaphoresis (sweating), headaches, lethargy, confusion, hemoptysis (coughing up blood), cough, pleuritic pain (sharp, stabbing chest pain that worsens with breathing, coughing, or sneezing). A subsequent Care Plan revision on 1/09/26 included anticoagulant medication use and directed staff to report observations of blood tinged or frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs to the nurse. Another subsequent revision on 3/17/26 indicated the resident had pneumonia that resolved 3/17/26. A document titled Fax Communication to Physician dated 3/30/26 at 8:05 AM marked Response Required indicated Staff E, Registered Nurse (RN) faxed the resident's physician the following information: re

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on observations, staff interview, and policy review the facility failed to post in a prominent place, readily available to residents, staff, and visitors, the facility's daily staff data consisting of the total number of staff (registered nurses (RNs), licensed practical nurses (LPNs), certified nurse aides (CNAs), certified medication assistants (CMAs)), actual hours worked by the staff, and resident census. The facility reported a census of 34 residents.Findings include: Observed on 4/19/26 at 9:20 AM the facility's posted daily staffing sheet was dated Saturday, 4/18/26.Observed on 4/19/26 at 3:00 PM the facility's posted daily staffing sheet was dated Saturday, 4/18/26.Observed on 4/19/26 at 4:30 PM the facility's posted daily staffing sheet was dated Saturday, 4/18/26.Observed on 4/20/26 at 7:10 AM the facility's posted daily staffing sheet was dated Saturday, 4/18/26.Observed on 4/20/26 at 9:25 AM the facility's posted daily staffing sheet was dated Monday, 4/20/26. In an interview on 4/21/26 at 4:05 PM the Director of Nursing (DON) stated the overnight nurse was responsible for updating the staffing sheet. The DON stated on 4/20/26 mid morning she discovered the staffing sheet had not been updated, and through that discovery it was found the overnight nurse did not have access to complete the staffing form. In an interview of 4/21/26 at 4:20 PM the Administrator acknowledged the nurse staffing sheet should have been updated on 4/19/26. The facility's Nursing Staff Daily Posting Requirements reviewed on 12/1/25 revealed that the facility will post daily at the beginning of each shift and update as appropriate the document with the location name, current date, resident census, total number and actual hours for RNs, LPNs, CNAs, and CMAs.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 policy review the facility failed to prepare, serve and distribute food in accordance with food service safety for general practices of mealtime service. The facility failed to identify and date opened packages of food in the kitchen, properly store food, and complete infection control practices while assisting residents during mealtimes. The facility reported a census of 34 residents.Findings include: On 4/19/26 at 9:33 AM, an initial kitchen tour revealed the following items: a. An undated, previously opened bottle of ranch dressing b. An undated, previously opened carton of liquid eggs c. A box of squash, sliced bread loaves, french fries, potato taters stored on the freezer floor d. Three (3) opened, undated, unlabeled, clear bags of breaded meat products e. A case of six (6) cans of chili con carne stored in the delivery carton on the floor in the dry goods storage room f. Two (2) undated plastic cereal containers On 4/22/26 at 2:33 PM, the Director of Nursing (DON) stated staff should've labeled, dated, and stocked items correctly. A policy titled Food-Supply Storage-Food and Nutrition Services revised 3/13/26 indicated all food/supply items are stored six inches off the floor and foods that have been opened or prepared are placed in an enclosed container, dated, labeled and stored properly. Continuous observation of the meal service on 4/19/26 at 12:00 PM revealed the following: a. There were 30 residents and 3 staff in the dining room. b. Resident #36 coughing frequently throughout the meal. c. Staff L, Certified Nursing Assistant (CNA) sat next to Resident #36 without hand hygiene. d. Staff I, CNA, seated at table with Resident #25 providing total assistance for meal consumption. e. Staff I stopped assisting Resident #25 and turned to a table behind her to assist Resident #15. The staff cut Resident #15's food. No hand hygiene between assisting Resident #25 and Resident #15. f. Staff M, CNA, moved from 1 assisted dining table to another to assist Resident #9 without completing hand hygiene. The staff obtained a beverage, returned to another table and provided total assistance for intake to Resident #12. g. Staff L left the dining room to assist residents back to their rooms. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	h. Staff I moved between Resident #25 and Resident #15 providing assistance to both (different tables). Staff I provided verbal, visual and tactile assistance to Resident #15 and total assistance to Resident #25. Staff I did not complete hand hygiene between the residents. i. Staff M changed tables to assist Resident #23 without hand hygiene. j. Resident #12 attempted self feeding and dropped her plate to her lap and subsequently the floor. k. Staff M observed the Resident #12's plate on the floor, picked up the spilled food from the floor, placed it on the plate, placed the plate on the table and picked up additional food from the resident's clothing protector. The staff left the table, obtained a wet paper towel, wiped the floor, touched the resident's plate, threw the trash away and returned to the table. Staff M then picked up Resident #12's glass by the rim and assisted the resident with a drink. Staff M moved Resident #12's dessert plate closer to her. Staff M did not offer Resident #12 additional food or complete hand hygiene. l. Staff I assisted Resident #25 without hand hygiene after touching Resident #15's arms and providing assistance. m. Staff L returned to the dining room and began assisting Resident #23 and #9 without hand hygiene prior to assisting and between residents. n. Staff L moved between Resident #23 and Resident #36 without completing hand hygiene. o. Staff L moved to assist Resident #18 without hand hygiene. p. Staff M had left the dining area and returned to assist Resident #18 without hand hygiene. q. Staff I left the assisted dining table area to assist another resident in the dining room, returned to assisting Resident #15 without hand hygiene. r. Staff N, Housekeeping/CNA, entered the dining room and sat at the assisted table with residents without completing hand hygiene. Continuous observation on 4/21/26 at 11:53 AM revealed the following: a. Staff I provided assistance to Resident #25. Staff turned to assist Resident #15 at another table without completing hand hygiene. b. Staff C, Certified Medication Aide (CMA), entered the dining room, applied Resident #36's clothing protector, touched her shirt, glasses, Resident #12's silverware and provided total assistance for the meal to the resident. Staff C did not complete any hand hygiene. c. Staff P, CNA, entered the dining room, touched a stool and proceeded to provide assistance to Resident #25. The staff did not complete any hand hygiene. In an interview on 4/21/26 at 2:45 PM Staff I stated staff should not go between residents without completing hand hygiene. In an interview on 4/21/26 at 3:00 PM Staff S, CNA, stated if a resident spilled food they may pick up (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the food if necessary or notify the dietary staff. The staff stated if they move between residents to provide assistance, staff must sanitize their hands. In an interview on 4/21/26 at 4:05 PM the Director of Nursing (DON) stated if the staff move between residents they should complete hand hygiene with either hand sanitizer or by washing hands. The DON stated if a resident had spilled their food, staff should notify the Dietary Department to assist with cleanup and/or provide a new plate of food. The DON stated if the staff assist with cleanup then hand hygiene should be completed. In an interview on 4/21/26 at 4:20 PM the Administrator concurred that hand hygiene should be performed between residents. The facility's Hand Hygiene Policy, reviewed 11/13/25, identified hand hygiene included either the use of antiseptic hand sanitizer or antiseptic hand wash. The document revealed that hand hygiene is routinely monitored in all patient care areas. The policy disclosed that hand hygiene was the single most important factor in preventing the spread of disease-causing organisms to patients and personnel in healthcare settings. On 4/21/26 at 1:04 PM Staff R, Certified Dietary Manager (CDM) stated she worked between 2 facilities but was at this facility Monday and Tuesday every week. Staff R stated if a family member requested a resident have bite size food with meals she was not aware of it. Staff R explained to her knowledge no resident family members had requested a resident receive bite size food. Staff R explained mechanically altered diets can always be downgraded for medical reasons or personal preference. Staff R said the beef / broccoli stir fry served for lunch on 4/21/26 was bigger than bite size. On 4/23/26 at 3:52 PM Staff U, CDM stated she worked between 2 facilities with Staff R. Staff U explained everything in the kitchen as far as food items should have been labeled and marked when the item was opened. Staff U said there should not have been any food items on the floor.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, pharmacist interview and staff interviews the facility failed to offer the residents at the facility COVID-19 immunizations and the residents did not receive the COVID-19 immunizations for 2025 year for 5 of 5 residents reviewed (Resident #9, #10, #12, #14, and #15). The facility reported a census of 34 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE] documented Resident #9 had a Brief Interview for Mental Status (BIMS) of 3 indicating severe cognitive impairment.Review of Resident #9's electronic health record (EHR) titled, Immunizations documented Resident #9 was last offered a COVID-19 immunization on 12/10/24.On 4/23/26 at 12:42 PM Staff V, Registered Nurse (RN) / Infection Preventionist (IP) stated for resident immunizations a nurse got the order to give the vaccine, obtained the consent or declination and administered the vaccine at the facility. Staff V explained the COVID-19 vaccine was usually offered every year. Staff V said the immunization / vaccine tracking system had been integrated into the EHR system. Staff V said he could not find a declination or consent for Resident #9. Staff V stated the formulation for COVID-19 vaccination was changed for the 2025 year and the facility did not get the guidelines for the 2025 year. Staff V stated COVID-19 vaccines were not given to residents at the facility at all unless the resident specifically requested the vaccine. 2. The MDS dated [DATE] documented Resident #10 had a BIMS of 12 indicating moderate cognitive impairment. Review of Resident #10's EHR titled, Immunizations documented Resident #10 was last offered a COVID-19 immunization on 12/10/24.3. The MDS dated [DATE] documented Resident #12 had a BIMS of 2 indicating severe cognitive impairment.Review of Resident #12's EHR titled, Immunizations documented Resident #12 was last offered a COVID-19 immunization on 12/10/24.4. The MDS dated [DATE] documented Resident #14 had a BIMS of 13 indicating no cognitive impairment.Review of Resident #14's EHR titled, Immunizations documented Resident #14 had not been offered a COVID-19 immunization since he entered the facility on 4/2/26.5. The MDS dated [DATE] documented Resident #15 had a BIMS of 7 indicating moderate cognitive impairment.Review of Resident #15's EHR titled, Immunizations documented Resident #15 was last offered a COVID-19 immunization on 7/17/24.On 4/23/26 at 1:16 PM the Director of Nursing (DON) stated the facility did not administer the COVID-19 vaccine at all for 2025. The DON explained the vaccine was in-between formulary. The DON stated the facility had been talking to the pharmacy back and forth. The DON explained the pharmacy could not get the new vaccine. The DON acknowledged the COVID-19 should be offered yearly if available. The DON explained the COVID-19 vaccine would have been administered in December 2025. The DON explained the Center for Disease Control (CDC) had not given any guidance on the COVID-19 vaccination for the 2025 yearOn 4/23/26 at 2:31 PM Staff W, Pharmacist explained the facility has always ordered from them. Staff W stated she had talked to the DON and was able to order the vaccine for 4/24/26. Staff W explained the DON stated she was waiting for a new formula guidance. Staff V stated the DON might have been thinking back to when the COVID-19 vaccine was not recommended for anyone under 65. Staff V stated there was a resident at the facility that had requested the vaccine and the vaccine was given if the resident had requested one. Staff V explained if the vaccine was given this month then in 6 months after the first one they should have a second for residents that were 65 years. Staff V stated if the residents received the COVID-19 now they will be caught up for the 2026-2027 year.Review of policy provided by the facility with a review date of 9/21/23 titled, Immunization / Vaccinations for Resident, Pneumococcal, Influenza, COVID-19 documented it was recommended that all clients and residents receive COVID-19 Vaccination per CDC Guidelines for eligibility and timing.Review of the Center for Disease Control website dated 11/19/26 documented it was especially important to get the 2025-2026 COVID-19 vaccine for ages 65 and older, are at high risk for severe COVID-19 or had never received a COVID-19 vaccine.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and policy review, the facility failed to fully inform the resident and/or representative of alternative psychotropic medication options by failing to identify target behaviors or non-pharmacological interventions on psychotropic medication (medications that affect a person's mental state, emotions, and behavior) consent forms for 3 of 5 residents (#4, #7, and #30) reviewed. The facility reported a census of 34 residents. 1.Resident #4's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated the resident was admitted to the facility on [DATE]. It also identified a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of anxiety and depression. It further revealed the resident took antianxiety and antidepressant medications in the 7-day look-back period.The Electronic Health Record (EHR) included two (2) physician's orders dated 12/02/25 for an antianxiety medication three (3) times per day for anxiety and an antidepressant medication daily for depression.An eAdmin Record (Default Note) Progress Note dated 12/02/25 revealed the antianxiety medication was on order.A document titled Permission For Use Of Psychotropic Medications dated 2/25 revealed the resident was educated on 12/02/25 regarding the use and side effects of the antianxiety and antidepressant medications. The form did not include the resident's anxiety or depression related behaviors nor facility attempted non-pharmacological alternatives.2. Resident #7's MDS assessment dated [DATE] indicated the resident was admitted to the facility on [DATE]. It also identified a BIMS score of 03 out of 15 which indicated severely impaired cognition. It included diagnoses of non-Alzheimer's dementia, anxiety, and depression. It further revealed the resident took antianxiety, antidepressant, and antipsychotic medications in the 7-day look-back period and exhibited verbal behavioral symptoms directed toward others.The EHR included a physician's order dated 8/08/25 for an antidepressant medication in the mornings.A document titled Permission For Use Of Psychotropic Medications dated 2/25 revealed the resident was educated on 8/08/25 regarding the use and side effects of the antidepressant medication. The form indicated sadness was the symptom but did not include the resident's sadness related behavior nor the facility attempted non-pharmacological alternatives.The EHR included a physician's order dated 2/13/26 to increase the antidepressant medication dose.A document titled Permission For Use Of Psychotropic Medications dated 2/25 revealed the resident's representative was educated on 2/13/26 regarding the use and side effects of the antidepressant medication. The form did not include the resident's depression related behavior nor the facility attempted non-pharmacological alternatives.The EHR included two (2) physician's orders dated 3/23/26 for an antianxiety medication every six (6) hours as needed for restlessness and to increase the antidepressant medication dose.A document titled Permission For Use Of Psychotropic Medications dated 2/25 revealed the resident's representative was educated on 3/23/26 regarding the use and side effects of the antianxiety and antidepressant medications. The form did not include the resident's anxiety or depression related behavior nor the facility attempted non-pharmacological alternatives.The EHR included three (3) physician's orders dated 3/26/26 for an antipsychotic medication at bedtime, to increase the antianxiety medication to every 4-6 hours as needed, and to decrease the antidepressant medication dose.A document titled Permission For Use Of Psychotropic Medications dated 2/25 revealed the resident's representative was educated on 3/27/26 regarding the use and side effects of the antidepressant medication. The form did not include the resident's psychosis, anxiety, or depression related behavior nor the facility attempted non-pharmacological alternatives.3. Resident #30's MDS assessment dated [DATE] indicated the resident was admitted to the facility on [DATE]. It also identified a BIMS score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of anxiety and cognitive communication deficit (communication impairment caused by cognitive issues). It revealed the resident took an antidepressant medication in the 7-day look-back period.The EHR included a physician's order dated (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/22/25 for an antidepressant medication at bedtime.Two (2) documents titled Permission For Use Of Psychotropic Medications dated 2/25 revealed the resident's representative was educated on 4/22/25 regarding the use and side effects of the antidepressant medication. The form did not include the resident's anxiety related behavior nor the facility attempted non-pharmacological alternatives.The EHR included a physician's order dated 6/26/25 for an antianxiety medication every 8 hours as needed for agitation for 7 days.A document titled Permission For Use Of Psychotropic Medications dated 2/25 revealed the resident's representative was educated on 6/26/25 regarding the use and side effects of the antianxiety medication. The form did not include the resident's anxiety related behavior nor the facility attempted non-pharmacological alternatives.The EHR included a physician's order dated 1/27/26 for an antianxiety medication every 8 hours as needed for anxiety for 7 days.A document titled Permission For Use Of Psychotropic Medications dated 2/25 revealed the resident was educated on 1/27/26 regarding the use and side effects of the antianxiety and antidepressant medication. The form did not include the resident's anxiety or depression related behavior nor the facility attempted non-pharmacological alternatives.On 4/22/26 at 10:39 AM, the Social Services Coordinator stated she was not aware the resident's behaviors and facility attempted non-pharmacological alternatives had to be listed on the consent form.On 4/22/26 at 11:57 AM, the MDS Coordinator stated she was not aware the resident's behaviors and facility attempted non-pharmacological alternatives had to be listed on the consent form.On 4/22/26 at 2:38 PM, the Director of Nursing (DON) stated staff should've completed the consent form in its entirety.A policy titled Psychotropic Medications - Rehab/Skilled revised 12/09/25 revealed before administration of non-emergency psychotropic medications, the following must be completed:a. Documentation in <the EHR> observations of mood, symptoms or behaviors that cause the resident distress and/or endanger the resident or others and response to interventions used.b. The behavior committee and/or care plan team will ensure the care plan is updated. This update will reflect non-pharmacological interventions to be used.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, clinical record review, and policy review the facility failed to provide a clean and homelike environment when a visibly soiled pillow case was observed two days in a row for 1 of 3 residents reviewed (Resident #6). The facility reported a census of 35 residentsFindings Include:Review of Resident #6 Minimum Data Set (MDS) dated [DATE] revealed an admission date of 7/31/20. The MDS documented Resident #6 had a Brief Interview for Mental Status (BIMS) score of 15 indicating cognitively intact mental status. The MDS indicated diagnoses of stroke, hemiplegia and hemiparesis.Observation on 4/20/26 at 9:18 AM noted a large u-shaped body pillow present on Resident #6's bed on top of the comforter with the white pillow case observed to have yellow and brown discoloration to both bottom sections of the u-shaped body pillow's white pillow case.On 4/20/26 at 9:18 AM Resident #6 explained she requested the u-shaped body pillow from her family because she was afraid she would fall out of bed.Observation on 4/21/26 at 1:23 PM revealed a large u-shaped body pillow observed on Resident #6's bed on top of the comforter with yellow and brown discoloration noted on both lower sections of the u-shaped body pillow's white pillow case. Observation on 4/21/26 at 1:49 PM revealed a large u-shaped body pillow on top of the comforter on Resident #6's bed with yellow and brown discoloration noted to both lower sections of the u-shaped body pillow's white pillow case. Staff D, Certified Nurse Assistant / Certified Medication Aide (CNA/CMA) turned the u-shaped body pillow over revealing the other side had a yellow and brown discoloration to both lower sections of the u-shaped body pillow's pillow case. Staff Q, Environmental Service Director entered the residents room while Staff D was turning the u-shaped body pillow over and Staff Q requested that Staff D remove the pillow case and replace it with a new one. Staff D removed the first pillow case revealing a second pillow case with yellow and brown discoloration observed to the lower sections of the u-shaped body pillow pillow case. Staff Q then removed the second pillow case and replaced it with a clean white pillow case. Interview on 4/21/26 at 1:23 PM Resident #6 stated she had not seen anyone remove the u-shaped body pillow pillow case and wash it. She explained when the CNA's made her bed they would move the u-shaped body pillow into her recliner. She said they make her bed and after the linen change is completed they will place the u-shaped body pillow back on the bed on top of the comforter. She stated the sheets are cleaned when she showers because the staff tells her they were changed but does not know if they were changed as she does not see them do it. States she would like her u-shaped body pillow case and her sheets to be cleaned regularly and when visibly dirty.On 4/21/26 at 1:36 PM with Staff O,CNA/CMA explained that Resident #6 uses a big u-shaped body pillow when in bed and that Resident #6 prefers to use it. Staff O explained the u-shaped body pillow pillow case is supposed to be removed and washed weekly with her bed linens. She stated there is a list behind the nurses station to show weekly bed linen changes for each of the residents. Staff O stated the last time the u-shaped body pillow was changed was on 4/20/26 with her bed linens per the list behind the nurses station. Staff O stated the u-shaped body pillow is currently on Resident #6's bed at this time.On 4/21/26 at 1:55 PM Staff Q explained the u-shaped body pillow case is supposed to be changed weekly according to the list behind the nurses station. Staff Q stated there should only be one pillow case on the u-shaped body pillow at a time. She stated she came into the residents room because Staff O told her she did not know where the pillow cases were kept after her interview with the surveyor. Staff Q stated after reviewing the change linen task sheet it revealed the u-shaped body pillow pillow case was changed on 4/20/26. Staff Q stated that she was not sure if it had been changed because of the double pillow case's present and the visible stains present when she observed the u-shape body pillow on 4/21/26. Staff Q stated the u-shaped body pillow pillow case is expected to be changed on shower/bath days and when visibly dirty.On 4/23/26 at 1:26 PM Staff T, Director of Nursing (DON) explained the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	u-shaped body pillow pillow case is changed on Resident #6's shower day. Staff T stated there is an organization sheet for linen changes for the pillow case. She stated she would expect the u-shaped body pillow pillow case to be changed if soiled in-between Resident #6's shower days. On review of Policy provided by the facility with an updated review date of 12/29/25 titled, Bedmaking-R/S, LTC documented to provide a clean bed for each resident. To promote physical comfort when a resident is in bed. Clean bed linens included: sheets, draw sheets, pillowcase's, bedspread's, blanket's and mattress cover's or pad's. Policy included bedmaking clinical skills checklist of an occupied and unoccupied bed procedure with instructions to remove soiled linen from residents bed and place in laundry bag or hamper.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and policy review, the facility failed to identify and consistently document non-pharmacologic behavior interventions for 3 of 5 residents (#4, #7, & #30) who received psychotropic medications (medications that affect a person's mental state, emotions, and behavior). The facility reported a census of 34 residents. Findings include:1.Resident #4's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated the resident was admitted to the facility on [DATE]. It also identified a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of anxiety and depression. It further revealed the resident took antianxiety and antidepressant medications in the 7-day look-back period.The Electronic Health Record (EHR) included two (2) physician's orders dated 12/02/25 for an antianxiety medication three (3) times per day for anxiety and an antidepressant medication daily for depression.A document titled Permission For Use Of Psychotropic Medications dated 2/25 revealed the resident was educated on 12/02/25 regarding the use and side effects of the antianxiety and antidepressant medications. The form did not include the resident's anxiety or depression related behaviors nor facility attempted non-pharmacological alternatives.The Care Plan revised 12/04/25 included antidepressant and antianxiety medication use and directed staff to attempt resident specific, nonpharmacological interventions but did not identify the resident's anxiety or depression related behaviors for staff to monitor.The Progress Notes included behavior monitoring documentation but did not identify what behaviors were observed nor staff attempted, non-pharmacological interventions.The Electronic Health Record (EHR) included an April 2026 Treatment Administration Record (TAR) document for staff to monitor behaviors due to receiving psychoactive medications every shift but did not identify the behaviors for staff to monitor. The TAR did not include staff attempted, non-pharmacological interventions.2. Resident #7's MDS assessment dated [DATE] indicated the resident was admitted to the facility on [DATE]. It also identified a BIMS score of 03 out of 15 which indicated severely impaired cognition. It included diagnoses of non-Alzheimer's dementia, anxiety, and depression. It further revealed the resident took antianxiety, antidepressant, and antipsychotic medications in the 7-day look-back period and exhibited verbal behavioral symptoms directed toward others.The EHR included a physician's order dated 8/08/25 for an antidepressant medication in the mornings.A document titled Permission For Use Of Psychotropic Medications dated 2/25 revealed the resident was educated on 8/08/25 regarding the use and side effects of the antidepressant medication. The form indicated sadness was the symptom but did not include the resident's sadness related behavior nor the facility attempted non-pharmacological alternatives.The EHR included a physician's order dated 2/13/26 to increase the antidepressant medication dose.A document titled Permission For Use Of Psychotropic Medications dated 2/25 revealed the resident's representative was educated on 2/13/26 regarding the use and side effects of the antidepressant medication. The form did not include the resident's depression related behavior nor the facility attempted non-pharmacological alternatives.The EHR included two (2) physician's orders dated 3/23/26 for an antianxiety medication every six (6) hours as needed for restlessness and to increase the antidepressant medication dose.A document titled Permission For Use Of Psychotropic Medications dated 2/25 revealed the resident's representative was educated on 3/23/26 regarding the use and side effects of the antianxiety and antidepressant medications. The form did not include the resident's anxiety or depression related behavior nor the facility attempted non-pharmacological alternatives.The EHR included three (3) physician's orders dated 3/26/26 for an antipsychotic medication at bedtime, to increase the antianxiety medication to every 4-6 hours as needed, and to decrease the antidepressant medication dose.A document titled Permission For Use Of Psychotropic Medications dated 2/25 revealed the resident's representative was educated on 3/27/26 regarding (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the use and side effects of the antidepressant medication. The form did not include the resident's psychosis, anxiety, or depression related behavior nor the facility attempted non-pharmacological alternatives.The Care Plan revised 3/24/26 included antidepressant, antipsychotic, and antianxiety medication use and directed staff to attempt resident specific, nonpharmacological interventions for psychosis and depression but not anxiety. The Care Plan also failed to include resident specific depression or anxiety behaviors for staff to monitor.An eAdmin Record (Default Note) Progress Note dated 3/29/26 at 12:34 PM indicated the resident received an antianxiety medication for agitation/anxiety for stating she needed to get out of the facility. It did not include documented staff attempted, non-pharmacological interventions.The EHR included an April 2026 TAR document that did not identify the behaviors for staff to monitor nor staff attempted, non-pharmacological interventions.3. Resident #30's MDS assessment dated [DATE] indicated the resident was admitted to the facility on [DATE]. It also identified a BIMS score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of anxiety and cognitive communication deficit (communication impairment caused by cognitive issues). It revealed the resident took an antidepressant medication in the 7-day look-back period.The EHR included a physician's order dated 4/22/25 for an antidepressant medication at bedtime.Two (2) documents titled Permission For Use Of Psychotropic Medications dated 2/25 revealed the resident's representative was educated on 4/22/25 regarding the use and side effects of the antidepressant medication. The form did not include the resident's anxiety related behavior nor the facility attempted non-pharmacological alternatives.The EHR included a physician's order dated 6/26/25 for an antianxiety medication every 8 hours as needed for agitation for 7 days.A document titled Permission For Use Of Psychotropic Medications dated 2/25 revealed the resident's representative was educated on 6/26/25 regarding the use and side effects of the antianxiety medication. The form did not include the resident's anxiety related behavior nor the facility attempted non-pharmacological alternatives.The EHR included a physician's order dated 1/27/26 for an antianxiety medication every 8 hours as needed for anxiety for 7 days.A document titled Permission For Use Of Psychotropic Medications dated 2/25 revealed the resident was educated on 1/27/26 regarding the use and side effects of the antianxiety and antidepressant medication. The form did not include the resident's anxiety or depression related behavior nor the facility attempted non-pharmacological alternatives.On 4/22/26 at 10:39 AM, the Social Services Coordinator stated she was not aware the resident's behaviors and facility attempted non-pharmacological alternatives had to be listed on the consent form.On 4/22/26 at 11:57 AM, the MDS Coordinator stated she was not aware the resident's behaviors and facility attempted non-pharmacological alternatives had to be listed on the consent form.The Care Plan revised 10/28/25 included antidepressant medication use but did not identify anxiety related behaviors nor nonpharmacological interventions for staff to attempt.The Progress Notes did not identify anxiety related resident behaviors nor staff attempted, non-pharmacological interventions.The EHR included an April 2026 TAR document that did not identify the behaviors for staff to monitor nor staff attempted, non-pharmacological interventions.On 4/21/26 at 12:17 PM, Staff A, Registered Nurse (RN) stated residents' target behaviors and non-pharmacological interventions should be documented in the residents' Care Plans. She also stated documented monitoring should be in the resident's TAR.On 4/21/26 at 12:45 PM, Staff B, RN stated she thinks the residents' target behaviors and non-pharmacological interventions should be documented in the residents' Care Plans but wasn't sure they were normally put in there. She added it was always normal to try non-pharmacological interventions before medication use.On 4/22/26 at 2:38 PM, the Director of Nursing (DON) stated staff should identify the target behaviors and use that to determine the appropriate non-pharmacological interventions.Before administration of non-emergency psychotropic medications, thefollowing must be completed:a. Documentation in PCC - POC observations of mood, symptoms or behaviors that cause the resident distress and/or endanger the resident or others and response to interventions used.b. The behavior committee and/or care plan team will ensure the care plan is updated. This update will reflect non-pharmacological interventions to be used.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, and staff interview the facility failed to complete a discharge summary that included a recapitulation of the resident's stay, a final summary of the resident's status, and reconciliation of all pre- and post-discharge medications for 1 of 3 residents reviewed (Resident #40). The facility reported a census of 34 residents.Findings include:The Minimum Data Set (MDS) dated [DATE] documented Resident #40 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment.Review of Resident #40's EHR dated 2/20/26 titled, Discharge Summary documented no recapitulation of stay, final summary of resident's status or reconciliation of pre- and post-discharge medications. Review of Resident #40's document titled, Fax dated 2/20/26 at 3:37 PM documented physician signed discharge summary 2/20/26 with Resident #40's discharge on [DATE] at 1:00 PM.On 4/23/26 at 1:24 PM the Director of Nursing (DON) stated she expected the discharge summary for Resident #40 would be completed after the discharge of Resident #40. The DON acknowledged Resident #40's discharge summary was not completed with recapitulation of stay, final summary of the resident's status or reconciliation of pre- and post-discharge medications. The DON stated she would expect the discharge summary would have been completed by now. Review of a policy provided by the facility reviewed 9/8/25 titled, Admission, Transfer, and Discharge Team documented admissions, transfers and discharges will be conducted according to state and federal regulations.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review the facility failed to complete a Pre-admission Screening and Resident Review (PASRR) for 1 of 1 residents (Resident #33), who was diagnosed with a new mental disorder diagnosis since admission to the facility. The facility reported a census of 34 residents.Findings include:The facility provided document PASRR completed on 10/4/22 identified the following: No mental health diagnoses.No mental health services.No mental health medications.No Level II required. The clinical record census disclosed Resident #33 was admitted to the facility on [DATE].The Minimum Data Set (MDS) assessment dated [DATE] for Resident #33 identified a Brief Interview for Mental Status (BIMS) score of 00 indicating severe cognitive impairment. The MDS recorded no signs and symptoms of delirium, no mood or behaviors during the reporting period. The MDS documented diagnoses that included:Non-Alzheimer's Dementia, depression, psychotic disorder and visual hallucinations. The MDS documented the resident received antipsychotic and antidepressant medications on 7 out of 7 days of the assessment reference period. The MDS assessment dated [DATE] for Resident #33 recorded the resident had fluctuating inattention and disorganized thinking, feeling of tired or little energy 7-11 days of the assessment period and no delusions or hallucinations. The MDS documented no psychiatric or mood disorder diagnoses. The MDS documented the resident did not receive antipsychotic or antidepressant medications on 7 out of 7 days of the assessment reference period. The Care Plan revised on 3/23/26 identified the resident had behavior symptoms related to hallucinations and accusations of missing items (clothing, money, purse) and then items may be found (initiated 6/27/24 and revised 6/6/25). The Care Plan identified staff interventions to provide positive interaction, assist in locating items and provide encouragement and active support when the resident is having hallucinations. The Care Plan identified antipsychotic medication related to hallucinations and vascular dementia with mood disturbance and delusional disorder (initiated 5/8/25). The Care Plan identified staff interventions with monitoring resident's condition related to Risperdal, and warnings for side effects. The clinical record's medical diagnoses included: Visual hallucinations dated 9/27/22 present on admission.Major depressive disorder, single episode, moderate dated 4/18/24, during stay.Delusional disorders dated 6/6/24, during stay.Vascular dementia, moderate, with mood disturbance dated 4/18/24, during stay. The clinical record's physician orders included:Sertraline HCl Oral Tablet 50 mg, 1 tablet daily (QD) related to major depressive disorder, single episode, moderate 8/15/25.Sertraline HCl Oral Tablet 25 mg, 1 tablet (QD) related to major depressive disorder, single episode 8/14/25. Lorazepam Oral Tablet .5 mg, .5 mg by mouth every 8 hours as needed for anxiety twice daily (BID) 7/30/25. Risperdal Oral Tablet .5 mg, .5 mg by mouth BID for antipsychotic related to visual hallucinations and delusional disorders. The facility document Consent dated 4/17/25 revealed consent for antipsychotic medication, Risperdal and antidepressant medication, Sertraline. In an interview on 4/21/26 at 9:50 AM the Director of Nursing (DON) stated the Social Services Director completed the PASRR. The DON stated residents came into the facility with a PASRR in place.In an interview on 4/21/26 at 9:52 AM the Social Services Director acknowledged she completed PASRRs when required. The staff referred to Resident #33's PASRR and concurred the document did not contain medications or mental health diagnoses. The Social Services Director stated the resident did currently receive psychotropic medications and has mental health diagnoses. The staff stated the resident should have had a new PASRR completed when new mental health diagnoses or medications are initiated. In an interview on 4/21/26 at 10:00 AM the DON concurred that when a new mental health diagnosis or medication is begun a resident should have a new PASRR completed. In an interview on 4/21/26 at 4:00 PM the Administrator acknowledged the facility did not complete a PASRR when a resident had a new mental health diagnosis and/or medication when a resident did not previously have one. The facility policy (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	titled Pre-admission Screening and Resident Review (PASRR) - Rehab/Skilled reviewed 12/29/25 directed staff that a new PASRR evaluation must be initiated when a resident is diagnosed with a mental disorder. The document disclosed the facility should notify the state-designated mental health authority promptly when a resident experiences a significant change.

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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 clinical record reviews, staff interview, and policy review, the facility failed to develop a personalized Care Plan that included resident specific target behaviors or non-pharmacological interventions for 3 of 5 residents (#4, #7, & #30) who received psychotropic medications (medications that affect a person's mental state, emotions, and behavior). The facility reported a census of 34 residents. Findings include:1.Resident #4's quarterly Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of anxiety and depression. It revealed the resident received antidepressant and antianxiety medications during the 7-day look-back period.The Electronic Health Record (EHR) included physician's orders dated 12/02/25 for an antidepressant medication one time per day and an antianxiety medication three times per day.The Care Plan revised 12/04/25 included antidepressant and antianxiety medication use and directed staff to attempt resident specific, nonpharmacological interventions but did not identify the resident's anxiety or depression related behaviors for staff to monitor or anxiety-related non-pharmacological interventions for staff to attempt.The April 2026 Medication Administration Record (MAR) revealed Resident #4 received the antidepressant and antianxiety medications since 4/01/26.2. Resident #7's MDS assessment dated [DATE] identified a BIMS score of 03 out of 15 which indicated severely impaired cognition. It included diagnoses of non-Alzheimer's dementia, anxiety, and depression. It further revealed the resident took antianxiety, antidepressant, and antipsychotic medications in the 7-day look-back period and exhibited verbal behavioral symptoms directed toward others.The EHR included a physician's order dated 8/08/25 for an antidepressant medication in the mornings; and two (2) orders dated 3/26/26 for an antianxiety medication every 4-6 hours as needed and an antipsychotic medication at bedtime.The Care Plan revised 4/07/26 included antidepressant, antipsychotic, and antianxiety medication use. It identified psychosis related target behaviors but not depression or anxiety related target behaviors. It also directed staff to attempt resident specific, nonpharmacological interventions for psychosis and depression but not anxiety.The April 2026 MAR revealed Resident #7 received the antidepressant, antianxiety, and antipsychotic medications since 4/01/26.3. Resident #30's MDS assessment dated [DATE] identified a BIMS score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of anxiety and cognitive communication deficit (communication impairment caused by cognitive issues). It revealed the resident took an antidepressant medication in the 7-day look-back period.The EHR included a physician's order dated 4/22/25 for an antidepressant medication at bedtime for generalized anxiety.The Care Plan revised 10/28/25 included antidepressant medication use but did not identify anxiety related target behaviors nor nonpharmacological interventions for staff to attempt.The April 2026 MAR revealed Resident #30 received the antidepressant medication since 4/01/26.On 4/21/26 at 12:17 PM, Staff A, Registered Nurse (RN) stated residents' target behaviors and non-pharmacological interventions should be documented in the residents' Care Plans. She also stated documented monitoring should be in the resident's TAR.On 4/21/26 at 12:45 PM, Staff B, RN stated she thinks the residents' target behaviors and non-pharmacological interventions should be documented in the residents' Care Plans but wasn't sure they were normally put in there. She added it was always normal to try non-pharmacological interventions before medication use.On 4/22/26 at 2:33 PM, the MDS Coordinator stated she did not know the target behaviors and non-pharmacological interventions had to be in the residents' Care Plans.On 4/22/26 at 2:38 PM, the Director of Nursing (DON) stated staff should've included the target behaviors and non-pharmacological interventions in the residents' Care Plans.A policy titled Care Plan - R/S, LTC, Therapy & Rehab revised 12/01/25 indicated each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, family interview, staff interviews, and policy review, the facility failed to ensure 1 of 14 residents (Resident #28) activities of daily living (ADL) abilities were maintained or improved. The facility failed to cut a resident's meat prior to serving as the family had requested. The facility reported a census of 34 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #28 identified a Brief Interview for Mental Status (BIMS) of 4/16 indicating severe cognitive impairment. The MDS revealed the resident was independent with eating. The MDS documented no limitations in range of motion of upper or lower extremities. The Care Plan revised 3/11/26 identified the resident had an ADL self care performance deficit that directed staff that resident feeds self after set up. The Care Plan identified a potential nutritional problem that directed staff to cut up all meat and inform the resident what is on her plate and location using the clock method (revised 5/15/24). The clinical record's Physician Orders revealed a regular diet, 7 regular texture, 0 thin consistency dated 5/11/23. The clinical record's Progress Note titled Care Conference Note on 1/29/26 at 1:14 PM revealed the family member requested the resident get more assistance in the morning and night, and that the resident's meat is cut up at meals. The entry revealed the MDS Coordinator, Social Services, the Dietary Manager and the family member were in attendance. Observed during the noon meal on 4/21/26 at 12:02 PM an unidentified kitchen staff serve Resident #28 her meal. The staff placed the plate containing the entree (beef / broccoli stir fry) and dessert plates in front of the resident and walked away. The staff did not have a verbal interaction with the resident. Observed 1 resident independently cut her meat and 2 staff members cut 2 assisted residents' entree prior to initiating consumption. Resident #28 did not make an attempt to cut her meat. Observed the meat pieces on the resident's plate were larger than 1.5 cm x 1.5 cm. Observed on 4/21/26 at 4:20 PM Resident #28's meal ticket. The diet ticket identified the resident had a regular diet, 7 regular texture and thin (0) liquids. The document did not reflect orienting the plate for the resident or cutting the resident's meat prior to serving. In an interview on 4/19/26 at 3:56 PM Resident #28's family member stated she had asked the facility to cut up the resident's meat as the resident's vision was deteriorating. In an interview on 4/21/26 at 1:04 PM Staff R, Certified Dietary Manager (CDM) stated if a family member requested a resident have bite size food she was not aware of it. Staff R stated to her knowledge no resident family members had requested a resident receive bite size food. Staff R explained mechanically altered diets can always be downgraded for medical reasons or personal preference. The staff stated the beef / broccoli stir fry was bigger than bite size. In an interview on 4/21/26 at 2:45 PM Staff I, Certified Nurse Assistant (CNA), stated if residents were seated at the assisted table then the CNA's will assist residents with cutting up food. Staff I stated she was unsure who would assist the residents if they were seated at the independent tables. In an interview on 4/21/26 at 4:05 PM the Director of Nursing (DON) stated the dietary aides were responsible for cutting up the residents' food and orienting the plate(s). The DON stated the information for cutting food, orienting, and adaptive equipment should be on the tray card. In an interview on 4/21/26 at 4:20 PM the Administrator stated all things meal related should be identified on the resident's meal card and completed by kitchen staff. In an interview on 4/21/26 at 4:39 PM Staff J stated Resident #28's meal ticket did not identify set up or cutting meat. The facility's Dining Assistant Policy, reviewed 1/29/26, revealed that dining assistance can be provided to a resident by a member of the nursing staff that included cutting meat, pouring liquids, and providing assistants to consume meals. The International Dysphagia Diet Standardization Initiative (IDDSI) revealed a Level 6 Diet Soft and Bite Sized indicated pieces were no bigger than 1.5 cm and 1.5 cm in size. The IDDSI Level 7 Regular Easy to Chew required no restrictions and normal everyday foods.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165191	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan - Red Oak	201 Alix Avenue Red Oak, IA 51566

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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 observation, clinical record review, staff interview, and policy review, the facility failed to provide appropriate toileting hygiene assistance to prevent a urinary tract infection (UTI) for 1 of 1 resident (#7). The facility reported a census of 34 residents.Findings include:Resident #7's MDS assessment dated [DATE] identified a BIMS score of 03 out of 15 which indicated severely impaired cognition. It included diagnoses of non-Alzheimer's dementia, anxiety, diabetes mellitus, and the need for assistance with personal care. It revealed the resident was frequently incontinent with bladder and bowel, required maximal assistance with toileting transfers, and was dependent with toileting hygiene.The Care Plan revised 4/07/26 included bladder incontinence as a focus and indicated the resident used incontinence briefs. It directed staff to assist with changing as needed or as requested. It revealed the resident had a UTI on 4/02/26 and directed staff to assist the resident with handwashing after being toileted and before and after meals.During a continuous observation on 4/22/26 that began at 10:20 AM, Staff M, Certified Nurse Aide (CNA) transported Resident #7 into her room in her wheelchair. Staff M put on gloves, grabbed a gait belt, put it on the resident, turned on the restroom light, pushed the resident's wheelchair closer to the restroom, moved the resident's wheelchair foot pedals, locked the wheelchair, helped the resident stand up, pulled the resident's pants and briefs down, and assisted the resident to the toilet. While the resident urinated, Staff M grabbed a periwipe packet and paper towels. She removed three periwipes and laid them on the paper towel on the edge of the sink. When the resident was finished urinating, Staff M assisted the resident to a standing position and wiped the resident's perineal area one time from behind and helped the resident pull her briefs and pants up. Staff M removed her gloves, grabbed the gait belt, assisted the resident to her wheelchair, and transported her back into her room. Staff M did not perform hand hygiene or change gloves between touching the objects in the resident's room and wiping the resident's perineal area.At 10:27 AM, Staff M stated she received annual infection prevention education that included hand hygiene and glove use. She stated she imagined touching items in a resident's room could contaminate the gloves and stated maybe she should've changed her gloves and performed hand hygiene after touching the resident's belongings and before wiping the resident's peri area.On 4/22/26 at 2:38 PM, the Director of Nursing (DON) stated staff should've followed the policy.A policy titled Hand Hygiene revised 11/13/25 indicated all employees in patient care areas (unless otherwise noted in their policy) will adhere to the 4 Moments of Hand Hygiene and 2 Zones of Hand Hygiene.1. Entering Room2. Before Clean Task3. After Bodily Fluid/Glove Removal4. Exiting Room5. Zones: Patient zone and Health-care zones.The policy defined Patient Zone as: concept related to the geographical visualization of key momentsfor hand hygiene. It contains the patient and their immediate surroundings. Typically includes intact skin of the patient and all inanimate surfaces that are touched by or in direct physical contact with the patient.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165191	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan - Red Oak	201 Alix Avenue Red Oak, IA 51566

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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 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 clinical record, observations, resident interview, staff interviews, and policy review, the facility failed to provide respiratory care and services in accordance with professional standards of practice for 1 of 1 residents (Resident #14) reviewed, requiring the use of oxygen. The facility failed to provide a resident's oxygen at the amount as documented in the physician's orders. The facility reported a census of 28 residents.Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #14 revealed a Brief Interview for Mental Status (BIMS) score of 13/15 indicating normal cognition. The MDS recorded diabetes mellitus, chronic obstructive pulmonary disease (COPD) and dependence on supplemental oxygen. The document disclosed the resident had health conditions of shortness of breath with exertion and shortness of breath when lying flat. The MDS revealed the resident utilized oxygen while a resident and during the last 14 days of the assessment period. The Care Plan revised on 2/3/26 identified Resident #14 had COPD with a staff directive to apply oxygen therapy at 2 liters per minute (lpm) via nasal cannula continuous. The Care Plan identified shortness of breath related to hypoxia with staff directives to apply oxygen therapy at 2 lpm via nasal cannula continuous and monitor, report to nurse changes in orientation, increased restlessness, anxiety and air hunger. The clinical record's Physician Orders revealed oxygen via nasal cannula 2 lpm, continuous for dyspnea, hypoxia dated 4/2/25. The Physician Orders revealed to change oxygen tubing on concentrator, tank and nebulizer weekly; place date and initials on tubing. Observed on 4/19/26 at 1:29 PM Resident #14 lying in bed with oxygen via nasal cannula with the concentrator set at 3 lpm. Observed on 4/20/26 at 1:45 PM Resident #14 sleeping in bed with oxygen via nasal cannula with the concentrator set at 3 lpm.Observed on 4/21/26 at 9:11 AM Resident #14 lying in bed with oxygen via nasal cannula with the concentrator set at 3 lpm. In an interview on 4/19/26 at 1:29 PM Resident #14 stated he had used oxygen since before he came into the facility. The resident stated his oxygen order had recently changed to 3 lpm from 2 lpm. In an interview on 4/21/26 at 2:45 PM Staff I stated Resident #14 did not mess with his oxygen settings that she was aware of.In an interview on 4/21/26 at 3:56 PM Staff K, Registered Nurse (RN) stated Resident #14 stayed in his bed all the time and rarely got out of bed. The staff stated the resident did not have a history of changing his oxygen.In an interview on 4/21/26 at 4:05 PM the Director of Nursing (DON) stated the concentrator should be set at the lpm according to the physician orders. The DON stated if the concentrator did not reflect the correct lpm as per physician orders the concentrator setting must be changed. In an interview on 4/21/26 at 4:20 PM the Administrator stated the staff should follow physician orders for the use of oxygen. The facility's Oxygen Administration, Safety, Mask Types Policy, reviewed 7/30/25, revealed oxygen administration is carried out only with a medical order. The policy disclosed the licensed nurse or other employee trained in the use of oxygen will be on duty and is responsible for the proper administration of oxygen of the resident.