STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195380	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Guest House Skilled Nursing and Rehabilitation	9225 Normandie Drive Shreveport, LA 71118

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record review and interview, the facility failed to ensure an RN (Registered Nurse) was on duty for 8 consecutive hours per day, 7 days a week, for 2 days within FY (Fiscal Year) Quarter 1, 2025 (October 1- December 31). Findings:Review of the facility's payroll summary report provided by S6 Human Resources for the FY Quarter 1 2025 revealed 8 dates with 1 RN (Registered Nurse) coverage. Further review revealed 2 of the 8 dates (10/05/2025 = 6.30 hours and 11/30/2025 = 7.55 hours) indicating RN coverage less than 8 hours. During an interview on 06/04/2026 at 10:00 a.m. S6 Human Resources reviewed and confirmed the facility did not have RN coverage for 8 consecutive hours for 10/05/2025 and 11/30/2025 as required. During an interview on 06/04/2026 at 11:00 a.m. S2 DON (Director of Nursing) reviewed and confirmed there should have been RN coverage for 8 hours per day and was not.

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on record review, observation, and interviews, the facility failed to ensure residents' right to a dignified existence in an environment that promotes maintenance and enhancement of quality of life for 1 (#127) of 1 resident reviewed for dignity. The facility failed to provide privacy for Resident #127 while in a community hall shower room.Findings:Review of the facility's policy titled Resident Rights (version 1.2) revealed, in part:Policy StatementEmployees shall treat all residents with kindness, respect and dignity.Policy Interpretation and Implementation1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:a. a dignified existenceb. be treated with respect, kindness, and dignity .e. self-determination .h. be supported by the facility in exercising his or her rights .Review of Resident #127's medical record revealed an admission date of 01/23/2026 with diagnoses that included cerebral ischemia, hepatic encephalopathy, and depression.Review of Resident #127's 04/30/2026 quarterly MDS (Minimum Data Set) revealed a BIMS (Brief Interview Mental Status) score of 15, indicating intact cognition. During an interview on 06/02/2026 at 12:10 p.m. Resident #127 reported the shower in resident #127's room had no water pressure and had to use the shower in the shower room across the hall. Resident #127 further reported a few days ago Resident #127 went into the shower room and made sure the sign on the outside of the door was changed to in use. While taking a shower, another resident opened the door which made Resident #127 mad and holler, Can't you read the sign?Observation on 06/02/2026 at 12:20 p.m. revealed 2 shower rooms across the hall from Resident #127's room, at the entrance to Hall A. Further observation revealed signage on the outside of each of the doors that could be changed to open or in use. Observation further revealed both of the door signs read in use and no one was in either of the shower rooms. Observation of the inside of each of the shower rooms also revealed each room was an open room with a shower head on the far wall, nothing to block sight between the door and the shower and each of the doors could not be locked from the inside.During an interview on 06/03/2026 at 1:38 p.m. Resident #127 reported entering the shower room around 8:30 a.m., changed the sign outside of the door to in use, went into shower room, put the shower chair in front of the door, and while taking a shower, a staff member barreled into the shower room. Resident #127 reported being furious when staff came in without knocking and continued to hold the door open even though Resident #127 was uncovered.During an interview on 06/02/2026 at 4:24 p.m. S7 CNA (Certified Nursing Assistant) Coordinator observed all community hall shower rooms with this surveyor and confirmed there were 2 shower rooms on Hall A and 1 shower room on Hall B without anything to block residents in the shower from being seen when the door is open.During an interview on 06/20/2026 at 4:30 p.m. S1 Administrator and S8 Corporate Nurse reported there was nothing to block residents from being seen when a resident was in the shower and the entry door was opened for 2 showers on Hall A and 1 shower on Hall B.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record reviews and interviews, the facility failed to ensure an alleged violation of resident to resident physical abuse was reported to the appropriate state agency within 2 hours after the allegations were made for 2 (#11 and #88) of 27 sampled residents. Resident #11 was subject to physical abuse by Resident #88. Findings: Review of the facility's Protocols for Reporting Abuse undated policy revealed in part: Policy Statement: Each facility will ensure that when suspicion or allegations of abuse occur, reporting and investigations are followed per company protocols. Any Facility that has an allegation of Abuse will follow the Protocols below: Administrator and DON (Director of Nursing) will review Algorithms from state agencies and CMS (Centers for Medicare and Medicaid Services) pertaining to abuse reporting when determining abuse and discuss with RVP's (Regional [NAME] President). An investigation must begin in order to have information pertinent to the two (2) hour time frame reporting (Crimes will be reported within two (2) hours). During an interview on 06/03/2026 at 8:50 a.m. S11 LPN (licensed practical nurse) reported she was the nurse assigned to both Resident #11 and Resident #88 on 01/25/2026. S11 LPN reported on 01/25/2026 around 10:00 a.m. she witnessed Resident #88 push Resident #11 down from behind and Resident #11 fell to the ground. S11 LPN reported she and a CNA (Certified Nursing Assistant) separated the two residents and Resident #11 was put into her room and was assessed to have a facial bruise. S11 LPN reported Resident #88 was placed in the common area by the nurse's station and on 01/25/2026 at around 12:30 p.m. S11 LPN reported Resident #88 pushed Resident #11 down to the floor a second time and started dragging Resident #11 by the hair down the hallway towards the exit. S11 LPN reported Resident #88 was sent to a local emergency room due to behaviors. S11 LPN acknowledged she had not documented the second incident of physical abuse to Resident #11 on 01/25/2026 at 12:30 p.m. or an assessment of Resident #11 and should have.During a one on one interview on 06/03/2026 at 11:30 a.m., Resident #11 reported she and her husband (Resident #88) had an altercation while in the facility and Resident #88 hit her in the face. Resident #11 reported she had a black and blue eye and was afraid when this happened. During an interview on 06/03/2026 at 2:20 p.m., S1 Administrator reported he was aware Resident #88 had behaviors upon discussion with family prior to admission but not to the extent of what happened. S1 Administrator reported Resident #88 was confused due to new environment and was sent to the hospital after he struck his wife, Resident #11. During an interview on 06/03/2026 at 3:00 p.m., S2 DON acknowledged an incident report had not been completed on Resident #11 related to the 01/25/2026 incidents of physical abuse. During an interview on 06/03/2026 at 3:15 p.m., S1 Administrator, acknowledged the physical abuse incidents on 01/25/2026 had not been reported to the appropriate State Agency.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review and interviews, the facility failed to ensure a plan of care had been implemented for 1 (#11) of 27 sampled residents whose care plans were reviewed. The facility failed to administer Resident #11's monthly psychotropic medication dose as ordered. Findings: Review of Resident #11's medical record revealed an admission date of 12/31/2025 with diagnoses including in part, paranoid schizophrenia, dementia and generalized anxiety disorder. Review of Resident #11's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12 indicating moderately intact cognition. Further review of Resident #11's Quarterly MDS Assessment revealed Resident #11 received antipsychotic medication. Review of Resident #11's comprehensive care plan revealed Resident #11 had a diagnosis of Schizophrenia and was on psychotropic medications with an intervention to administer psychotropic medications as ordered by the physician. Review of Resident #11's physician orders revealed in part, an order dated 01/27/2026 for Invega Sustenna intramuscular suspension prefilled syringe 156 mg (milligram)/ml (milliliter) (Paliperidone Palmitate) (psychotropic); Inject 156 mg intramuscularly one time a day starting on the 28th and ending on the 28th every month related to paranoid schizophrenia. Review of Resident #11's May 2026 Medication Administration Record (MAR) revealed Invega Sustenna intramuscular suspension prefilled syringe 156 mg/ml monthly dose had not been administered. Review of the Pharmacy Manifest dated 05/29/2026 revealed Resident #11's Invega Sustenna 156 mg prefilled syringe was delivered to the facility on [DATE] at 2:51 p.m. and signed by S10 Unit Manager on 05/30/2026 as received. During an interview on 06/02/2026 at 2:00 p.m., S2 Director of Nursing (DON) reviewed Resident #11's May 2026 MAR and acknowledged the monthly dose of Invega Sustenna 156 mg had not been administered. S2 DON reported the facility did not have Resident #11's monthly dosage in stock and she approved the cost of the medication on 05/28/2026 for the pharmacy to fill. S2 DON reported she informed S10 Unit Manager to enter a new order for the May 2026 monthly dose once the medication was received by the pharmacy. During an interview on 06/02/2026 at 2:20 p.m. S10 Unit Manager, reported Resident #11 did not have an available dose of Invega injection for the May 2026 monthly administration. S10 Unit Manager reported he had called the pharmacy a couple of times and was told Resident #11's dose had been delivered to the facility. S10 Unit Manager reported he found Resident #11's Invega prefilled syringe, yesterday, 06/01/2026. S10 Unit Manager reported he notified the Nurse Practitioner yesterday, 06/01/2026, and a one-time verbal order was received to get Resident #11 back on track. S10 Unit Manager stated it slipped my mind and failed to put in the Invega order for May, 2026. During an interview on 06/02/2026 at 2:30 p.m., S2 DON reviewed the Pharmacy Manifest and acknowledged Resident #11's Invega Sustenna156 mg prefilled syringe was delivered to the facility on [DATE] at 2:51 p.m. S2 DON reported Resident #11's medication should have been administered as soon as received on 05/29/2026 and was not.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, and interviews the facility failed to ensure residents who need respiratory care were provided care consistent with professional standards of practice for 3 (#37, #50, and #51) of 3 residents reviewed for respiratory care. The facility failed to ensure:1. O2 (oxygen) tubing was dated when changed for Residents #37, #50, and #51,2. humidification bottle was dated when changed for Resident #37,3. O2 tubing was bagged when not in use for Resident #37,4. nebulizer, Bipap (bi-level positive airway pressure) and Cpap (continuous positive airway pressure) masks were bagged when not in use for Residents #37, #50 and #51 and5. lung sounds were monitored after nebulizer treatment for Resident #50.Findings: Review of the facility's policy Oxygen Use (Respiratory Therapy) - Prevention of Infection revised November 2011 revealed in part:Purpose: The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff.Steps in the procedure:Infection Control Considerations related to Oxygen Administration 2. Use distilled water for humidification per facility protocol. 3. [NAME] bottle with date and initials upon opening and discard after 7 days. 7. Change the oxygen cannula and tubing every seven (7) days, or as needed. 8. Keep the oxygen cannula tubing used PRN (as needed) in a plastic bag when not in use,Infection Control Considerations Related to Medication Nebulizers/Continuous Aerosol: 7. Store the circuit in plastic bag or kangaroo pouch between uses . Change plastic bag with the administration set-up every seven (7) days. 9. Discard the administration set-up every seven (7) days. Documentation: The following information should be recorded in the resident's medical record: 1. The date and time the respiratory therapy was performed 2. The type of respiratory therapy performed. 4. All assessment data obtained during the treatment. Resident #37Review of Resident #37's medical record revealed an admit date of 09/15/2025 with diagnoses which include in part unspecified dementia, mild, with anxiety, chronic obstructive pulmonary disease, and obstructive sleep apnea. Review of Resident #37's physician orders revealed in part:06/03/2026 Oxygen: change mask, O2 tubing, water bottle and clean concentrator filter every night shift every Wednesday for maintenance.09/15/2025 Oxygen: Cpap q hs (every bedtime) related to obstructive sleep apnea. 09/15/2025 Oxygen: administer oxygen at 2 liter via n/c (nasal cannula) prn for sob (shortness of breath) or sat (saturation) >90% every shift related to immunodeficiency due to conditions classified elsewhere; chronic obstructive pulmonary disease, unspecified. Review of Resident #37's Quarterly MDS (Minimum Data Set) dated 03/18/2026 revealed in part a BIMS (Brief Interview for Mental Status) score of 15 indicating cognitively intact. Observation on 06/01/2026 at 8:35 a.m. revealed Resident #37 had an un-bagged, undated oxygen nasal cannula hanging on the headboard, no date on the oxygen humidification bottle and an un-bagged Cpap mask on the bedside table. During an interview on 06/01/2026 at 8:35 a.m. Resident #37 reported staff have not replaced the oxygen tubing in a really long time or provided a bag for storage for the oxygen tubing or mask when not in use. During an interview on 06/01/2026 at 8:57 a.m. S5 RN (Registered Nurse) confirmed the oxygen tubing and humidification bottle were not dated and the nasal cannula and Cpap mask were not bagged and should have been. Resident #50Review of Resident #50's medical record revealed an admit date of 02/07/2025 with diagnoses which include chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, unspecified, and unspecified asthma. Review of Resident #50's physician orders revealed in part:02/07/2025 Oxygen at 2 (two) liters via nasal cannula prn (as needed) for sob or sat <90% O2 sat every shift related to chronic respiratory failure with hypoxia.02/07/2025 Oxygen: Change mask, O2 tubing, water bottle and clean concentrator filter every night shift every Wednesday; change tubing label and date and as needed for contamination. 06/13/2025 Nebulizer: Assess after administering Nebulizer Treatment Document Lung Sounds as 1=Clear 2=Rales 3=Congested 4=Crackles 5=Rhonci 6=Rubs 7=Wheezing 8=Diminished four times a day. Review of Resident #50's Medication Administration Record (MAR) (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documentation for May 2026 failed to reveal monitoring of lung sounds after nebulizer treatments. Review of Resident #50's Quarterly MDS dated [DATE] revealed in part a brief interview for BIMS of 15 indicating cognitively intact. Special treatments: oxygen therapy, and participates in respiratory therapy. Observation on 06/01/2026 at 9:00 a.m. revealed Resident #50 with oxygen in use via nasal cannula, no date on oxygen cannula tubing, and a nebulizer sitting on the bedside table with the mask not bagged.Observation on 06/02/2026 at 10:00 a.m. revealed Resident #50 sitting up in a wheelchair, oxygen in use via nasal cannula, no date on the oxygen cannula tubing, and a nebulizer sitting on the bedside table with mask not bagged. During an interview on 06/02/2026 at 10:00 a.m. Resident #50 reported staff had not changed the oxygen cannula tubing and never bagged the nebulizer mask or listened to his lungs. During an interview on 06/02/2026 at 11:40 a.m. S3 LPN (Licensed Practical Nurse) confirmed Resident #50's oxygen cannula tubing was not dated and the nebulizer mask was not bagged and should have been. During an interview on 06/03/2026 at 9:42 a.m. S2 DON (Director of Nursing) reviewed Resident #50's medical record and confirmed the lung sounds after nebulizer treatments had not been documented as ordered and should have been.Resident #51Review of Resident #51's medical record revealed an admit date of 09/24/2025 with diagnoses which include in part chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia, and heart failure.Review of Resident #51's physician orders revealed in part:09/24/2025 Oxygen: Administer continuous oxygen at 4 Liters per nasal cannula may remove for adls (activities of daily living); keep hob (head of bed) elevated for sob while lying flat every shift related to chronic obstructive pulmonary disease, unspecified; acute and chronic respiratory failure with hypoxia. 09/24/2025 Bipap at 14/6/40% at bedtime 09/24/2025 Oxygen: Change mask, O2 tubing, water bottle and clean concentrator filter every night shift every Wednesday change tubing. Review of Resident #51's Quarterly MDS dated [DATE] revealed in part a BIMS score of 06 indicating severely impaired cognition. Observation on 06/01/2026 at 9:00 a.m. revealed Resident #51 with oxygen in use via nasal cannula with no date on the oxygen tubing, Cpap on bedside table with the hose on the floor, no mask attached and hose un-bagged. Observation on 06/02/2026 at 11:30 a.m. revealed Resident #51 in a wheelchair, oxygen in use via nasal cannula, no date on the oxygen tubing, and a Cpap on bedside table with the hose on the floor, no mask attached and hose un-bagged. During an interview on 06/02/2026 at 11:30 a.m. Resident #51 reported staff have not changed the oxygen tubing in a long time and have not provided a storage bag for the Cpap when not in use. During an interview on 06/02/2026 at 11:40 a.m. with S3 LPN confirmed Resident #51's oxygen was in use via nasal cannula, the oxygen tubing was not dated, cpap hose was on the floor with no mask attached and un-bagged. S3 LPN further confirmed the night shift should have dated the oxygen tubing and bagged the Cpap hose when not in use and did not.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on record review and interview, the facility failed to ensure a resident's drug regimen was free of unnecessary medications for 1 (#4) of 5 residents reviewed for unnecessary medications. The facility failed to monitor for edema for a resident receiving a diuretic. Findings:Review of Resident #4's medical record revealed an admission date of 08/30/2024 with diagnoses that included, in part, chronic pulmonary edema, essential (primary) hypertension, and chronic kidney disease stage 3A.Review of Resident #4's physician orders revealed a 04/09/2026 order for Lasix oral tablet 20mg (milligram) (Furosemide) - give 1 tablet by mouth every 8 hours as needed for leg swelling.Review of Resident #4's May 2026 MAR (Medication Administration Record) revealed Lasix oral tablet 20mg was administered on 05/23/2026, 05/25/2026, and 05/28/2026. Further review of Resident #4's May 2026 MAR failed to reveal Resident #4 had been monitored for edema.Review of Resident #4's care plan revealed, in part, resident is on diuretic therapy with interventions that included administer diuretic medications as ordered by physician; document edema: 0=none, 1=trace, 2=+2, 3=+3, 4=pitting; notify Medical Doctor if +3 or greater X3 consecutive days (initiated on 07/09/2025); and observe/document/report any adverse reactions to diuretic therapy.During an interview on 06/03/2026 at 3:30 p.m. S2 DON (Director of Nursing) reported she had reviewed Resident #4's medical record and confirmed there was no evidence monitoring for edema had been conducted in May 2026.

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F 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. Based on observation and interviews, the facility failed to ensure name, address, and telephone numbers of all pertinent State agencies were posted in a manner accessible to residents and resident representatives. The facility failed to post the LDH (Louisiana Department of Health) nursing home complaint phone number. Findings: Observation throughout facility on 06/03/2026 at 12:10 p.m. with S2 DON (Director of Nursing) revealed LDH Nursing Home complaint phone number was not posted in a place accessible to residents and resident representatives.During an interview on 06/03/2026 at 12:40 p.m. S2 DON reported the LDH Nursing home complaint phone number was not posted.During an interview on 06/04/2026 at 7:45 a.m. S1 Administrator confirmed the LDH Nursing Home complaint phone number was not posted.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record reviews and interview the facility failed to provide documentation regarding the existence of any written advance directives for 2 (#4, #20) of 2 residents reviewed for Advanced Directives.Findings:Review of the facility's policy titled Advance Directives (revised May 31, 2023) revealed:Policy StatementAdvance directives will be respected in accordance with state law and facility policy.Policy Interpretation and Implementation1. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so.6. Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives.8. If the resident indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives. Resident #4Review of Resident #4's medical record revealed an admission date of 08/30/2024 with diagnoses that included, in part, chronic pulmonary edema, diabetes mellitus, unstable angina, myocardial infarction, atherosclerotic heart disease of native coronary artery without angina pectoris, and essential (primary) hypertension.Review of Resident #4's Advanced Medical Directives Form dated 09/01/2024 revealed a section of the form which read: Please note whether an Advanced Directive has been executed: was incomplete with no box checked to indicate whether or not an Advanced Directive had been executed. Resident #20Review of Resident #20's medical record revealed an admission date of 10/06/2025 with diagnoses that included, in part, chronic obstructive disease pulmonary disease unspecified, type 2 diabetes mellitus, dementia in other diseases classified elsewhere mild with agitation, and atherosclerotic heart disease of native coronary artery without angina pectoris.Review of Resident #20's Advanced Medical Directives Form signed on 10/06/2025 revealed a section of form which read: Please note whether an Advanced Directive has been executed: was incomplete with no box checked to indicate whether or not an Advanced Directive had been executed.During an interview on 06/02/2026 at 3:53 p.m. S1 Administrator and S8 Corporate Nurse reviewed Resident #4 and Resident #20's Advanced Medical Directives Forms and confirmed the section which had unchecked boxes to indicate whether or not an Advanced Directive had been executed should have been completed and was not.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to accurately assess each resident's respiratory status by failing to ensure the Minimum Data Set (MDS) assessment was accurate for 1 (#37) of 27 total sampled residents.Findings:Review of Resident #37's medical record revealed an admit date of 09/15/2025 with diagnoses that include in part: Unspecified dementia, mild, with anxiety, chronic obstructive pulmonary disease, and obstructive sleep apnea. Review of resident #37's physician orders revealed in part:06/03/2026 Oxygen (02): Change Mask, 02 tubing, water bottle and clean concentrator filter every night shift every Wednesday for maintenance.09/15/2025 Oxygen: Cpap (Continuous Positive Airway Pressure) qhs (every night at bedtime) related to obstructive sleep apnea. 09/15/2025 Oxygen: administer oxygen at 2liter via n/c (nasal cannula) prn (as needed) for sob (shortness of breath) or sat (saturation) >90% every shift related to immunodeficiency due to conditions classified elsewhere; chronic obstructive pulmonary disease, unspecified. Review of Resident #37's quarterly MDS (Minimum Data Set) dated 03/18/2026 revealed in part a brief interview for mental status score of 15 indicating cognitively intact. Further reveiw failed to reveal REsidnet #37 required Oygen or respiratory therpay. During an interview on 06/04/2026 at 11:50 a.m. S4 MDS nurse reviewed Resident #37's medical record and confirmed the MDS dated [DATE] had an inaccurate assessment for respiratory and oxygen use. S4 MDS nurse reported the MDS should have been marked yes for oxygen use and respiratory treatment and was not.