STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225404	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspen Hill Rehabiliation & Healthcare Center	190 North Avenue Haverhill, MA 01830

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, policy review and interview, the facility failed to ensure dental services were provided for two Residents (#105 and #20) out of a total sample of 27 Residents. Specifically, the facility failed to:1. For Resident #105, the facility failed to acknowledge and implement the dentist's continued recommendations for the extractions of seven teeth.2. For Resident #20, the facility failed to ensure dental services were provided after being assessed by the contracted dentist on 10/22/2024, with recommendations.Findings include:Review of the facility policy titled Dental Services, dated and revised December 2016, indicated the following: - Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. - Routine and 24-hour emergency dental services are provided to our residents through: a contract agreement with a licensed dentist that comes to the facility monthly, referral to the resident's personal dentist, referral to community dentists, referral to other health care organizations that provide dental services. - Residents have the right to select dentists of their choice when dental care or services are needed. - Selected dentists must be available to provide follow-up care. - Medicare and Medicaid residents will be billed for routine and emergency dental services. - Social services representatives/designee will assist residents with appointments, transportation arrangements and for the reimbursement of dental services under the state plan, if eligible. 1. Resident #105 was admitted to the facility in June 2024 with diagnoses including chronic obstructive pulmonary disease, chronic respiratory failure, and dementia. Review of Resident #105's most recent Minimum Data Set Assessment (MDS), dated [DATE], indicated that the Resident had a Brief Interview for Mental Status score of 9 out of 15, indicating moderate cognitive impairment. During an interview on 1/6/26 at 7:45 A.M., Resident #105 was eating his/her breakfast in his/her room. Resident #105 said he/she was waiting for dentures for months, but he/she needs teeth removed first and he/she has been waiting for months. Resident #105 then said his/her mouth hurts all the time and it is hard to chew food and he/she needs to chew food slowly. During a follow-up interview on 1/6/26 at 2:20 P.M., Resident #105 said someone is supposed to take (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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	out his/her teeth, but no one has yet. Resident #105 showed the surveyor his/her bottom, middle teeth. The Surveyor observed seven teeth worn down to the gumline with multiple black markings on the teeth. The surrounding gums of the teeth appeared to be reddened and inflamed. Resident #105 then told the surveyor he/she wants to go out to a dentist and get them taken out because they hurt. Review of Resident #105's physician's orders indicated the following: - May go out for appointments – dated 8/7/23 Review of Resident #105's document titled Request for Service, for the facility's contracted dental company, indicated that the Resident's legal guardian requested for the Resident to be seen by dental services while in the facility, signed and dated 8/7/23. Review of Resident #105's oral/dental health problems care plan, dated 10/7/25, indicated the following interventions: - Coordinate arrangements for dental care, transportation as needed/as ordered - Monitor/document/report to physician PRN (as needed) s/sx (signs/symptoms) of oral/dental problems needing attention: pain (gums, toothache, palate), abscess, debris in mouth, teeth missing, loose, broken, eroded, decayed. Review of Resident #105's treatment notes from the facility's contracted Dentist dated 5/7/24, indicated the following: - Patient presents for periodic exam. Patient complains that bottom teeth hurt occasionally, comes and goes for the last two months. Doesn't specifically say which area. No swelling or exudate noted. Patient admits he/she doesn't brush his/her teeth often. Patient is now requesting dentures to be able to eat better. Recommend ext. (extraction) non-restorable teeth prior to fabrication of dentures: #23, 24, 25, 26, 31. Patient states he/she is afraid of needles and would like extractions done under sedation. Refer to Oral Surgery (OS) for extraction of teeth. Recommend follow up after referral to OS. Recommend FMX (full mouth x-rays) for insurance approval of partial denture - will ask for x-rays to be sent from OS. Discussed healing time prior to fabrication of dentures. Reviewed denture fabrication steps with patient. Discussed treatment plan and referral with his/her nurse. - Action Required by Nursing Home Staff: Refer to oral surgeon to extract #23, 24, 25, 26, 31. Please obtain x-rays from OS and email to [dentist's email address]. Review of Resident #105's treatment notes from the facility's contracted Dentist dated 4/17/25, indicated the following: - Reviewed Med (medical) Hx (history). Patient presents for annual exam. Remaining teeth are now all broken at gum level. Root tip #31 exfoliated. Patient aware this happened. Gingiva is generally severely inflamed. Patient complains it is uncomfortable. Stressed to patient that he/she still needs to brush his/her teeth even though they are all going to be extracted. Patient requests OS (oral surgery) to be sedated during extraction. Facility working on appt. (appointment). Discussed with Registered Nurse. Recommend annual exam. Recommend fabrication of complete set of dentures to improve chewing ability and quality of life. Reviewed denture fabrication steps with patient. Discussed healing time prior to fabrication of dentures. Recommend follow up after referral to OS. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Oral Exam Comments: Seen by dentist 10-6-25. She is referring to outside oral surgeon for possible bottom teeth extractions. He/she denies having any pain. He/she is edentulous on top and had step 1 denture fitting. During an interview on 1/7/26 at 11:21 A.M., Unit Manager #1 said Medical Records is in charge of making dental appointments and if a Resident needs an appointment then she would reach out to Medical Records. During a telephone interview on 1/7/26 at 1:03 P.M., the Nurse Practitioner (NP) said she was unaware that Resident #105 needed multiple teeth extracted for an extended amount of time. The NP said she would expect the facility to let her know if he/she was experiencing any dental pain. The NP further said the facility should arrange transportation for any dental appointment needed and she would expect the facility to set up oral surgery consultations as recommended by the dentist. During a telephone interview on 1/7/26 at 1:19 P.M., the Medical Director (MD) said he would expect any recommendations made by the dentist to be followed and typically whatever a specialty doctor recommends he is okay with doing. During an interview on 1/7/26 at 1:33 P.M., Nurse #1 said Resident #105 typically does not refuse care and is alert and oriented towards him/herself. During an interview on 1/7/26 at 1:42 P.M., the Medical Records staff said right now she is in charge of making outside appointments. She further said the nurses will let her know if a resident needs an appointment and she will arrange it which includes going to a specialty dentist such as an oral surgeon. The Medical Records staff then said she was not aware of Resident #105 needing any dental appointments. During an interview on 1/7/26 at 1:59 P.M. with the Director of Nursing (DON) and Unit Manager #1, the DON said the facility will obtain consents from residents to be seen by the consulting dentist on admission to the facility. The DON said when the dentist sees a resident, they will email a visit summary to herself and the Unit Managers and she will print it and send it to the Unit Managers who are responsible for following up. The DON said we will usually implement any recommendations that the dentist makes. The DON then said if we need permission from the Resident's Guardian we will reach out and she would expect staff to document any attempt made to speak with a Guardian. The DON continued to say she has not heard or seen any nursing documentation about dental follow-ups for Resident #105. The surveyor then discussed each treatment recommendation made by the dentist for Resident #105 and the DON said none of it is familiar sounding. The DON said at the time there was a different Unit Manager who no longer works here who should have been responsible for setting up Resident #105's appointments. The DON then said no one has come to the facility to attempt to extract Resident #105's teeth and the facility reached out to an outside dentist, but they were unable to see the Resident due to financial reasons. The DON said Resident #105 has an appointment in two days because they became aware of his/her dental needs and she said it should have been done sooner especially if there was documentation since April 2024 and documentation of Resident #105 being in severe discomfort. Review of the Resident #105's medical record on 1/7/26 indicated that the Administrator uploaded a consent for dental extractions on 1/7/26. During an interview on 1/7/26 at 2:34 P.M., the Administrator said the DON made her aware that extractions were needed for Resident #105, so she reached out to his/her guardian and heard back within the day. The Administrator said she was not (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the document titled Contracted Dental Group, dated 10/22/24, indicated the reason for visit, initial exam. Treatment notes: Clinical exam reveals generalized severe periodontitis, discussed with unit manager and recommend extracting the severely mobile teeth #2 and #23 to prevent choking or aspiration of teeth. Recommended treatment annual exam, prophy (professional care such as cleaning designed to prevent oral health issues) q (every) 6 months, extractions tooth #2;23, prior approval completed. During an interview on 1/6/25 at 2:01 P.M., Social Worker #1 said Resident #20 has been seen by the contracted dental services. The surveyor requested all contracted dental service documentation for Resident #20 and was provided with the initial exam dated 10/22/24, revealing Resident #20 had no further treatment from the contracted dental services provider. During an interview on 1/7/26 at 3:34 P.M., Unit manager #2 said she did not realize Resident #20 was not seen again since the initial exam with recommendations. Unit Manager #2 said she just got an email yesterday from the dental provider with a list of residents who have not been seen due to insurance coverage. Unit Manager #2 said if a resident has needs, they will be seen and they will work with the business office to work out the ins and outs of coverage. Unit Manager #2 said the dental provider sends a list of residents who will be treated and that she did not realize Resident #20 was not seen again and should have been. During an interview on 1/8/26 at 9:21 A.M., Unit Manager #2 said they cleared up the insurance issues. Unit Manger #2 said when the dentist has recommendations, they usually are seen on follow up visits. Unit Manager #2 said she had no idea they (the dentist) did not see Resident #20 because of an insurance issue. Resident #20 had several recommendations made by the dentist over 14 months ago that were not addressed. During an interview on 1/8/26 at 11:21 A.M., the Director of Nursing said it appears that the dental provider put the Resident on a do not treat list due to insurance verification. The DON said if it was brought to her or the Administrator's attention they would have assisted with making arrangement to have Resident #20 seen for services needed. During an interview on 1/8/26 at 2:05 P.M., the Administrator said Resident #20 was on a do not treat list from the dental provider and there was a communication issue. The Administrator said the Resident does have standard insurance and the facility should have identified that the Resident was not seen for the recommended dental services and the issue with insurance could have been solved sooner.

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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 record review and interview, the facility failed to obtain the necessary psychotropic consent for one Resident (#44) out of a total sample of 27 residents. Findings include: Review of the facility policy titled Psychotropic Medication Use, revised February 2025, indicated the following: Prior to initiating the use of, increasing the dose of, or switching to a different psychotropic medication, the staff and physician will review the following with the resident/representative prior to obtaining documented consent or refusalˆThe resident's/representative's right to accept or decline treatment. Resident #44 was admitted in June 2023 with diagnoses including dementia, anxiety, and depression. Review of the Minimum Data Set (MDS), dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 7 out of 15, indicating a severe cognitive impairment. Review of the physician's orders for Resident #44 indicated he/she was prescribed the following medications: Mirtazapine 7.5 milligrams (a medication used to treat depression), initiated 5/31/25. Lorazepam 0.5 milligrams (a medication used to treat anxiety), initiated 11/6/25.Duloxetine Hydrochloride 60 milligrams (a medication used to treat depression), initiated 6/8/23.Review of the medical record failed to indicate that any psychotropic consents were obtained. During an interview on 1/7/26 at 2:18 P.M., the Director of Nursing said that the facility could not locate the consents for psychotropics and that the facility sent new consents to the Resident's guardian for a signature.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure an advanced directive was current and not expired for one Resident (#20) out of a total sample of 27 residents. Specifically, for Resident #20 the facility failed to ensure the [NAME] Guardianship and Probate Court Treatment Plan (a guardian appointed by a judge in probate court who is responsible for making decisions for an individual after a judge has decided they are not competent to make their own informed choices, including treatment with antipsychotic medication) was reviewed prior to the court appointed [NAME] Treatment Plan expired.Findings include: Review of the facility's policy titled, Advance Directives, undated, indicated Advanced Directives will be respected in accordance with state law and facility policy. Policy Interpretation and Implementation included but not limited to, 6. Prior to 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. 7. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. 18. The interdisciplinary team will review annually with the resident his or advance directive to ensure that such directives are still the wishes of the resident. Such reviews will be made during the annual assessment process and recorded on the resident assessment instrument (MDS Minimum Data Set). Resident #20 was admitted to the facility in [DATE] with diagnoses including but not limited to mild cognitive impairment, hypertension, Schizophrenia, and anemia. Review of the most recent MDS assessment, dated [DATE], indicated Resident #20 scored 12 out of 15 on the Brief Interview for Mental Status exam, indicating moderately impaired cognition. Review of the MDS also indicated Resident #20 received antipsychotic medication on a routine basis.Review of Resident #20's medical record indicated the following:-A care plan, initiated [DATE] with a target date of [DATE] - I use antipsychotic medication.-A care plan initiated [DATE] with a target date of [DATE], for Advanced Directives - Resident has Court Appointed Guardian with [NAME] Order (expiration [DATE]). Review of Resident #20's medical record indicated a Decree and Order of Appointment of Gaudian for An Incapacitated Person dated as filed [DATE]. The powers and duties of the Guardian shall further include:After making a substituted judgment determination, the Court authorizes treatment of the Incapacitated Person: with antipsychotic medication in accordance with a treatment plan dated [DATE] which shall be reviewed on or before [DATE]. Review of the Treatment Plan indicated; This plan shall be reviewed one year from today's date on [DATE] and if not sooner extended, shall expire at 4 P.M. on that date, signed by a judicial designee.Further review of the Resident #20's medical record failed to have a current, not expired,Treatment Plan to administer antipsychotic medication. During an interview with Social Worker (SW) #1 and SW #2 on [DATE] at 1:36 P.M., SW#1 said Resident #20's [NAME] Treatment Plan expired in [DATE]. SW #1 said it came to her attention in [DATE] that Resident #20 had a [NAME] Treatment Plan and that it was expired. SW #1 said Resident #20 is administered antipsychotic medication. SW #1 said she called the Guardian to see if the Guardian filed for review of the [NAME] Treatment Plan. SW #1 said the Guardian did not petition for the Treatment Plan to be reviewed by the court and said she does not do that. SW #1 said then she contacted the facility's legal counsel to start the process to petition the court for review of Resident #20's [NAME] Treatment Plan.During an interview on [DATE] at 4:10 P.M., the Administrator said she became aware that Resident #20 had an expired [NAME] Treatment Plan sometime in [DATE]. The Administrator said the goal would be for the facility staff to start the process for the review of the [NAME] Treatment Plan prior to the expiration date.The failure to petition the court prior to the expired date of [DATE] resulted in Resident #20 having a court appointed expired [NAME] Treatment plan for nearly over 7 months.

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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 observations, record review and interview, the facility failed to ensure that activities of daily living were provided for one Resident (#79) out of a total sample of 27 Residents. Specifically, for Resident #79, the facility failed to ensure that the Resident received 1:1 (one to one) supervision while eating breakfast and that the plan of care was followed while Resident #79 was eating breakfast.Findings include: Review of the facility policy titled Activities of Daily Living (ADL), Supporting, dated and revised April 2025, indicated the following:- Residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.- Appropriate care and services are provided for residents who are unable to carry out ADLs independently, with the consent of the resident, and in accordance with the plan of care, including appropriate support and assistance with: dining (eating, including meals and snacks).Resident #79 was admitted to the facility in April 2015 with diagnoses including cervical disc disorder, dysphagia, and psychotic disorders. Review of Resident #79's most recent Minimum Data Set Assessment (MDS) dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 11 out of 15, indicating moderate cognitive impairment. Further review of the MDS indicated that the Resident requires supervision or touching assistance with eating. Review of Resident #79's ADL Self Care Performance Deficit care plan indicated the following interventions, dated 12/30/24:- 1:1 (one to one) supervision with meals. Use wrist weights for all meals. Pt. (patient) will also sit at sturdy table for all meals not bedside table to prevent table from rolling away and pt. spilling his/her meal.On 1/6/26 at 8:32 A.M., Resident #79 was sitting in a wheelchair in his/her room eating his/her breakfast from a tray placed on his/her bedside table. There were multiple scraps of dropped food all under the Resident's table and some eggs on the Resident's chest. Next to the Resident's tray was a pink wrist weight.On 1/7/26 at 7:38 A.M., two staff members were setting up Resident #79's breakfast tray on a bedside table while he/she was sitting in a wheelchair. The staff members then proceeded to leave the room. From 7:38 A.M. through 7:52 A.M., Resident #79 was eating his/her breakfast in his/her room with no supervision or assistance. The Resident was not wearing his/her wrist weight and there were multiple scraps of food on the ground beneath the Resident's tray.On 1/8/26 at 7:28 A.M., Certified Nursing Assistant (CNA) #1 was setting up Resident #79's breakfast tray on a bedside table while he/she was sitting in a wheelchair. At 7:30 A.M., CNA #1 left the room. At 7:41 A.M., Resident #79 waved down the surveyor and asked the surveyor for help peeling a banana. The surveyor informed CNA #1 who proceeded to help the Resident. CNA #1 then told the surveyor that Resident #79 does fine with eating as long as he/she was wearing his/her wrist weight as he/she has hand tremors, and it helps keep his/her hand steady. The surveyor asked CNA #1 if Resident #79 was wearing the wrist weight, CNA #1 proceeded to check and he/she was not and the wrist weight was located in the Resident's bathroom. CNA #1 then put the wrist weight on Resident #79. CNA #1 said the Resident can eat on his/her own as long as he/she is wearing the wrist weight. During another observation at 7:49 A.M., Resident #79 was still eating his/her breakfast with no supervision or assistance, there were multiple scraps of food beneath the Resident's tray on the ground.Review of Resident #79's discontinued physician's order dated 10/3/24 indicated the following:- 1:1 supervision with meals. Use wrist weights for all meals. Pt. (patient) will also sit at sturdy table for all meals not bedside table to prevent table from rolling away and pt. spilling his/her meal.Review of Resident #79's Kardex (a care card indicating the level of care a Resident needs) indicated the following under the Eating/Nutrition section:- 1:1 supervision with meals. Use wrist weights for all meals. Pt. (patient) will also sit at sturdy table for all meals not bedside table to prevent table from rolling away and pt. spilling his/her meal.Review of Resident #79's Speech Therapy Discharge summary dated from 8/29/24 - 10/31/24 indicated the following:- Skilled Interventions: Pt. was provided with skilled dysphagia services targeting safety with PO (by mouth) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225404	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspen Hill Rehabiliation & Healthcare Center	190 North Avenue Haverhill, MA 01830

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	intake of mechanical soft solid using safe swallow strategies. It has been determined that the pt. does require close supervision w/ intake due to inability to independently recall and carryover safety strategies. He/she has been deemed safe and an order is written that pt. may have grilled cheese sandwiches in dining room with close supervision.Review of the CNA documentation for December 2025 for eating indicated that 27 of 28 documented occurrences of eating breakfast that Resident #79 received only set-up assistance with the meal and not supervision.Review of the CNA documentation for January 2026 for eating indicated that 6 of 7 documented occurrences of eating breakfast that Resident #79 received only set-up assistance with the meal and not supervision.During an interview on 1/8/26 at 9:38 A.M., Nurse #1 said Resident #79 only needs set-up assistance with meals and he/she uses adaptive equipment because he/she has hand tremors. Nurse #1 said 1:1 supervision means that someone should be always watching a resident while they are eating. Nurse #1 and the surveyor reviewed Resident #79's care plans and she was not aware that that the Resident required 1:1 supervision and should be wearing wrist weights. Nurse #1 said she would expect the care plan to be followed.During an interview on 1/8/26 at 10:02 A.M., Unit Manager #1 said Resident #79 can self-feed and requires weighted wrist bands for his/her hand tremors. Unit Manager #1 said the CNAs are responsible for putting on the Resident's wrist band. The surveyor shared the breakfast observations and care plan with Unit Manager #1 and she was not aware the Resident requires 1:1 supervision and she said he/she should be wearing wrist weights with meals.During an interview on 1/8/26 at 11:05 A.M., the Director of Nursing (DON) said 1:1 supervision means someone should be with a resident while they are eating. The DON said Resident #79's care plans should be followed and his/her wrist weights should have been put on prior to eating and supervision should have been provided while he/she was eating his/her breakfast.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225404	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation record review and interview, the facility failed to ensure staff maintained an accurate medical record for one Resident (#16) out of a total sample of 27 residents. Specifically, the facility failed to accurately document and transcribe Resident #16's supplemental oxygen flow rate.Findings include: Review of the facility policy titled Oxygen Administration dated and revised October 2010, indicated the following:- Verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration.Resident #16 was admitted to the facility in May 2023 with diagnoses including asthma, morbid obesity and acute and chronic respiratory failure, chronic pulmonary edema, chronic diastolic heart failure.Review of Resident #16's most recent Minimum Data Set assessment dated [DATE] indicated that the Resident had a Brief Interview for Mental Status score of 15 out of 15 indicating intact cognition. Further review of the MDS indicated that the Resident receives oxygen therapy. The surveyor made the following observations:- On 1/6/26 at 8:13 A.M., Resident #16 was awake lying in bed receiving supplemental oxygen via nasal canula. The oxygen concentrator was set to 4.5 liters of supplemental oxygen.- On 1/7/26 at 7:34 A.M., Resident #16 was awake lying in bed receiving supplemental oxygen via nasal canula. The oxygen concentrator was set to 4.5 liters of supplemental oxygen.- On 1/7/26 at 12:30 P.M., Resident #16 was sleeping in bed receiving supplemental oxygen via nasal canula. The oxygen concentrator was set between 4 and 4.5 liters of supplemental oxygen.- On 1/8/26 at 7:26 A.M. Resident #16 was awake lying in bed receiving supplemental oxygen via nasal canula. The oxygen concentrator was set between 4 and 4.5 liters of supplemental oxygen. Resident #16 said he/she was having a hard time breathing this morning.Review of Resident #16's care plans indicated the following:- I am O2 (oxygen) dependent, SOB (shortness of breath) while lying flat r/t (related to) chronic respiratory failure, Asthma. On 4lpm (liters per minute) cont (continuous)Review of Resident #16's discontinued orders indicated the following:-Oxygen at 4L/minute via nasal cannula - discontinued 11/24/25From 11/24/25 through 11/28/25, Resident #16 was on a medical leave of absence in the hospital.Review of Resident #16's physician's order dated 11/28/25 indicated the following: Oxygen at 2L/Minute via Nasal Canula.Review of Resident #16's Medication Administration Record for January 2026 indicated that staff documented that Resident #16 received supplemental oxygen at 2 liters per minute despite his/her oxygen concentrator being set between 4-4.5 liters per minute.Review of a nursing progress note dated 11/28/25 indicated the following:- Resident returned to facility to the facility at 1:45 P.M. via ambulance on a stretcher. O2 sats (saturation) 93% on O2 (oxygen) at 2L (2 liter) nasal canula. Orders verified and call to on call regarding resident return.Review of a nursing progress note dated 12/10/25 indicated the following:- This writer went into resident's room to check oxygen at 1700. Resident was SATing at 72%. NC (nasal canula) was on and at 2L. TW (this writer) increased O2 to 4L and resident came up to 90%. On call stated to increase O2 to 4L for overnight.During an interview on 1/8/26 at 9:50 A.M., Nurse #1 said Resident #16 received supplemental oxygen at 4 liters. Nurse #1 and the surveyor reviewed Resident #16's physician's orders and she said the order for 2 liters is incorrect as Resident #16 should have his/her supplemental oxygen at 4 liters.During an interview on 1/8/26 at 10:36 A.M., the Respiratory Therapist said Resident #16 has been receiving supplemental oxygen at 4 liters for a while. The Respiratory Therapist said she believes that written order is a typo because if Resident #16 was receiving supplemental oxygen at 2 liters he/she would constantly be desatting (oxygen levels dropping).During an interview on 1/8/26 at 11:05 A.M., the Director of Nursing (DON) said Resident #16's oxygen order for 2 liters was put in incorrectly and it should have been put it for 4 liters. The DON said the Resident receives his/her oxygen at 4 liters and she is not sure why staff members were signing off that Resident #16 was receiving his/her oxygen at 2 liters and did not question the order being incorrect.