STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225520	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cambridge Rehabilitation & Nursing Center	8 Dana Street Cambridge, MA 02138

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, record review, and interviews, the facility failed to ensure staff stored drugs and biologicals in accordance with State and Federal laws. Specifically, the facility failed to ensure that two of two medication room refrigerators were maintained at an appropriate temperature for medication storage. Findings include:Review of the facility policy titled, Storage - Labeling - Maintenance of Medications, dated 7/8/25, indicated medications and biologicals are stored safely, securely, and properly, following manufacture's recommendations or those of the supplier. 2. Medications requiring refrigeration shall be kept separate from food. a. The refrigerator must maintain a proper temperature 36 to 46 degrees Fahrenheit. b. Medications requiring refrigeration or temperatures between 36 to 46 are kept in a refrigerator with a thermometer. 1. On 5/6/26 at 7:25 A.M., the surveyor and Nurse #4 observed in the first-floor medication room a medication refrigerator with a temperature reading as 52 degrees Fahrenheit (F). There was condensation observed within the refrigerator with drops of water dripping from the ice section on to the lower shelf. Inside the refrigerator were the following medications that were warm to touch: -two Insulin Lispro Injection pens, Manufacture's guidelines indicate to store in refrigerator at temperature between 36 degrees F and 46 degrees F. -three Prolia (denosumab) Injections, Manufacture's guidelines indicate to store in refrigerator at temperature between 36 degrees F and 46 degrees F. -ten Influenza Vaccine (Afluria) pre-filled syringes, Manufacture's guidelines indicate to store in refrigerator at temperature between 36 degrees F and 46 degrees F. -eight Trulicity (dulaglutide injection) pens, Manufacture's guidelines indicate to store in refrigerator at temperature between 36 degrees F and 46 degrees F. - two bottles of liquid Lorazepam Oral Concentrate, manufacture's guidelines indicate to store in a refrigerator at a temperature between 36 degrees F and 46 degrees F, to maintain stability and potency. -one Emergency Medication Kit containing: one injection vial of Insulin Glargine, one injection vial of NPH Insulin, and one injection vial of Insulin Lispro. Sticker from pharmacy indicated Maintain (continued on next page)

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Temperature Between 36 degrees F and 46 degrees F. On 5/6/26 at 7:35 A.M., the surveyor and Unit Manager #2 observed the temperature reading of 52 degrees F. Unit Manager #2 said she is not sure why it is warm and said the Maintenance Director changed out the thermometer last week because it was not working. Unit Manager #2 reviewed the daily refrigerator logs, and she said she was not sure why it was warm. During an interview on 5/6/26 at 7:43 A.M., Nurse #5 said sometimes the thermometer does not work and the temperature will read higher than it should and said the temperature was high last weekend, but she does not know why. Review of the documented Refrigerator Temperature Log for May 2026 was left blank and contained no documented temperatures on 5/1/26 and 5/4/26. Further review indicated 11 undocumented temperatures out of 30 days during the month of April. During an interview on 5/6/26 at 7:49 A.M., the Director of Maintenance said this is the first he has been notified of any issues with the refrigerator on the first-floor unit and said he was just asked to put a new thermometer into the refrigerator as it is not working. On 5/6/26 at 11:32 A.M., the surveyor along with Unit Manager #2 observed in the first-floor medication room a medication refrigerator with a temperature reading as 50 degrees Fahrenheit (F). During an interview 5/6/26 at 11:34 A.M., Unit Manager #2 said the temperature should not be that high and said the temperature should be below 50 degrees Fahrenheit. Unit Manager #2 said she would remove the medications to a different refrigerator. During an interview on 5/6/26 at 11:40 A.M., Nurse Practitioner (NP) #1 said medications requiring refrigeration must be within the recommended safe range and said 52 is not a safe range for medications storage. NP #1 said the medications must be thrown away as they are unsafe to administer if not kept in a safe temperature range. During an interview on 5/6/26 at 11:49 P.M., the Director of Nursing (DON) said that the medication room refrigerators must be checked and documented daily, and any unsafe range must be reported. The DON said medication manufacture's guidelines must be followed and said 52 degrees is not within a safe range. During an interview on 5/6/26 at 11:50 A.M., the Regional Clinical Nurse said the medications must be removed and discarded as they were not stored in a safe temperature range. On 5/6/26 at 12:05 P.M., the surveyor observed Unit Manager #2 bringing the medications removed from the first-floor refrigerator over to the second-floor refrigerator. 2. On 5/6/26 at 11:07 A.M., the surveyor and Nurse #2 observed in the second-floor medication room a medication refrigerator with an internal temperature reading as 28 degrees Fahrenheit (F). Inside the refrigerator were the following medications that were cold to touch: - seven Tresiba flex pens, manufacture's guidelines indicate to store unused Tresiba pens in the refrigerator at 36 degrees F to 46 degrees F. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- five Humalog flex pen, manufacture's guidelines indicate to store in a refrigerator at a temperature between 36 degrees F and 46 degrees F. - four Lantus flex pen, manufacture's guidelines indicate to store in a refrigerator at a temperature between 36 degrees F and 46 degrees F. - one NovoLog flex pen, manufacture's guidelines indicate to store in a refrigerator at a temperature between 36 degrees F and 46 degrees F - one bottle of liquid lorazepam, manufacture's guidelines indicate to store in a refrigerator at a temperature between 36 degrees F and 46 degrees F, to maintain stability and potency. - one vial of Humalog insulin, manufacture's guidelines indicate to store in a refrigerator at a temperature between 36 degrees F and 46 degrees F - one vial of Novolin N insulin, manufacture's guidelines indicate to store in a refrigerator at a temperature between 36 degrees F and 46 degrees F. - one vial of glargine insulin, manufacture's guidelines indicate to store in a refrigerator at a temperature between 36 degrees F and 46 degrees F. On 5/6/26 at 11:14 A.M., the surveyor and Unit Manager #1 observed the temperature reading of 28 degrees F. Unit Manager #1 said she was not sure why the medication refrigerator was so cold to touch. Unit Manager #1 reviewed the daily refrigerator logs, and she said she was not sure what happened today and she said that they recently received a new refrigerator. During an interview on 5/6/26 at 12:01 P.M., the Director of Nursing (DON) said that the medication room refrigerators temperatures should be set to the medication manufacture's guidelines. The DON and the surveyor went to the second-floor medication room. On 5/6/26 at 12:03 P.M., the surveyor and the DON observed the second-floor medication room refrigerator thermometer reading 32 degrees F. The temperature dial was set to the max setting. The DON said that she would review the manufacture's recommendations with nursing.

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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 observation and interview, the facility failed to ensure food is stored in accordance with professional standards of food safety and sanitation to prevent the spread of pathogens, which could result in foodborne illness for the residents. Specifically, the facility failed to ensure available food was not expired or showing signs of decompensation, and that food was dated and stored appropriately in the main kitchen refrigerator second-floor kitchenette.Findings include:Review of facility policy titled Storage and Labeling of Food Brought in by Family/ Visitors, dated as effective 6/25/25 indicated the following:-Properly stored and labeled refers to both the dating of all newly opened food and drink items provided by the facility as well as all food items brought in by family members for the residents and food items belonging to and brought in by staff members. All food and drink items are required to have proper labeling for easy identification.-The Kitchen Department will clean and inspect labeled food items in all unit refrigerators on a weekly basis. Any outdated items will be immediately discarded.On 5/4/26 at 6:55 A.M., the surveyor made the following observations in the fridge in the emergency food storage room with the Food Service Director.-A tray of plastic cups containing Coleslaw, dated 4/14/26.-An undated cup of pudding.-An undated bag containing a head of cabbage with brown leaves and signs of decompensation.-An open bin of green peppers, undated, with signs of decompensation and a white fuzzy substance on them.-A covered and undated bin of brown and wilting celery with signs of decompensation.-An undated bucket of gelatin.On 5/4/26 at 7:51 A.M., the surveyor observed, in the second-floor kitchenette fridge two pitchers of cranberry juice, one was labeled with a use by date of 5/2/26 and one was labeled with a use by date of 5/3/26.During an observation and interview on 5/4/26 at 6:57 A.M., the Food Service Director along with the surveyor observed the contents of the fridge in the emergency food storage room. The Food Service Director said that all food should be dated upon receiving, and or with an expiration date. She said all prepared foods should be labeled with a prepared date and expiration date. She said the peppers had mold on them and the celery and cabbage had signs of decompensation and should have been removed from the fridge.During an interview on 5/6/26 at 7:37 A.M., the Administrator said that the expectation is that the kitchen staff are checking the food daily and getting rid of anything that is expired. Further, he said that when food is prepared and stored in the fridge it should be labeled with the date it was prepared on, and the date it expires so that it can be disposed of on or before the expiration date.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to ensure that one Resident (#52) was free from significant medication errors out of a total sample of 18 residents. Specifically, for Resident #52, nursing staff failed to administer scheduled two units of Lispro insulin, and failed to administer 24 units of Insulin Glargine in accordance with the physician's order. Findings include: Review of the facility policy titled Administering Medications, dated 4/2024, indicated but was not limited to the following: Medications are administered in a safe and timely manner, and as prescribed. 2. Medications are administered in accordance with prescriber orders, including any required time frame. 3. Medication administration times are determined by resident need and benefit and as per MD (Medical Doctor) order. Factors that are considered include: a. Enhancing optimal therapeutic effect of the medication; b. Preventing potential medication or food interactions; and c. Honoring resident choices and preferences, consistent with his or her care plan. 5. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). 7. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall indicate this on the MAR (Medication Administration Record) space provided for that drug and dose and will inform the MD/NP (Nurse Practitioner). Resident #52 was admitted to the facility in September 2025 with diagnoses including type one diabetes mellitus, multiple sclerosis, and chronic pain syndrome. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #52 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 12 out of 15. The MDS indicated Resident #52 received insulin. During an interview on 5/6/26 at 7:20 A.M., Nurse #4 Resident #52 is diabetic and has orders for scheduled and sliding scale insulin in the morning and said she was going to administer the Residents insulin. Nurse #4 said she did not take Resident #52's blood sugar this morning. Review of Resident #52's plan of care related to diabetes, dated 9/19/25, indicated: -Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. -Fasting Serum Blood Sugar as ordered by doctor. Review of Resident #52's active physician orders, indicated the following: -Insulin Glargine Subcutaneous^Solution 100 units per milliliter (Unit/ml) (Insulin Glargine)^Inject 24 unit (s) subcutaneously (under the skin) one^time a day for diabetes,^hyperglycemia (high glucose/sugar levels in the blood) no parameter^needed. ^Start Date: 3/4/26. Scheduled for 8:00 A.M. -Insulin Lispro Injection Solution^(Insulin Lispro)^Inject 2 unit(s) subcutaneously one^time a day for diabetes with breakfast. Start Date: 5/5/26. Scheduled for 8:00 A.M. -Insulin Glargine Subcutaneous Solution 100 Unit/ml (Insulin Glargine) Inject 10 unit subcutaneously at bedtime for diabete [SIC] related to type 1 diabetes mellitus without complications. Start Date: 3/3/26. Scheduled for 10:00 P.M.During an observation and interview on 5/6/26 at 8:27 A.M., Resident #52 was observed in bed, a breakfast tray was on the overbed table, and Resident #52 was eating his/her breakfast meal. Resident #52 said he/she had not received his/her insulin that was due to be administered before breakfast. Resident #52 said he/she should have received the insulin this morning. Review of the Physician progress note dated 5/4/26 indicated Resident has difficult to control diabetes. Diabetes mellitus ranges from 70-400's over the past few weeks. Currently on Lantus 24 u (units) qAM (every morning) and 10 (units) qHS (every night) with Lispro sliding scale. Reviewed trends in EMR (Electronic Medical Record). I can't discern obvious temporal pattern; 6am glucose ranging from 74-393 in the last week. Pre-lunch, no lows range 130-448. Pre-dinner 2 readings in 70's last week, range 70's-280. 9pm (P.M.) glc (glucose) ranging from 89-372. -Start Lispro 2 units with breakfast only. -Continue Lispro sliding scale, and change times to before meals only.-Discontinue qHS Lispro sliding scale, risk for hypoglycemia. -Continue Lantus 24 units qAM, 10 units qPM for now. -If qHS coverage needed, would use regular insulin not lispro. -Repeat A1C in July On 5/6/26 at 8:40 A.M., Nurse #4 was observed sitting in a Residents (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room down the hall assisting another resident to eat. During an interview on 5/6/26 at 8:47 A.M., Nurse #4 said she had not checked Resident #52's blood sugar and had not administered insulin to Resident #52 because she had to stop the medication pass to check the breakfast cart and to help feed other residents with breakfast. Nurse #4 said when she is finished, she will continue with her medication pass. Nurse #4 said she should have administered the scheduled insulin this morning when it was scheduled but did not. Review of Resident #52's Medication Administration Record (MAR), dated May 2026, indicated on 5/6/26 at 9:25 A.M., failed to indicate any insulin was administered, was left blank and contained no documentation. Review of the Electronic Medical Record indicated the last documented blood sugar level was on 5/5/26. Review of Resident #52's Medication Administration History Report dated 5/6/26 at 11:57 A.M., indicated: -Nurse #4 administered the 8:00 A.M., scheduled 24 units of Insulin Glargine a 9:43 A.M., 1 hour and 43 minutes after the scheduled time. -Nurse #4 did not administer the 8:00 A.M., scheduled 2 units of Insulin Lispro with the breakfast meal. The documentation code was 11 indicating it was not administered. During an interview on 5/6/26 at 11:15 A.M., Nurse #4 said she did not administer the scheduled 2 units of Lispro insulin because she used her nursing judgement and said she did not notify the Nurse Practitioner or Physician and said she would only call if the Residents blood sugar dropped below 75. Nurse #4 said she did not give the Resident the scheduled Lispro because the Residents blood sugar was stable. Nurse #4 said she checked the Residents' blood sugar at 9:43 A.M., and it was 148. During an interview on 5/6/26 at 11:34 A.M., Unit Manager #2 said Resident #52, should have received the insulin as ordered by the physician. Unit Manager #2 said Resident #52 should have had his/her blood sugar obtained in the morning and insulin administered with the breakfast meal as ordered by the physician. During an interview on 5/6/26 at 11:37 A.M., Nurse Practitioner (NP) #1 said Resident #52 should have had his/her blood glucose levels checked in the morning before breakfast and said the scheduled insulin should have been administered as ordered with breakfast and said she was not notified that the scheduled 2 units of insulin was not given. During an interview on 5/6/26 at 11:45 A.M., the Director of Nursing (DON) said that nursing should obtain blood sugars and administer insulin as ordered. The DON said Resident #52 should have had his/her insulin administered before breakfast because that was the physician's order and said Nurses are expected to contact the provider if a medication is not given. During an interview on 5/6/26 at 11:47 A.M., the Regional Clinical Nurse said morning blood sugar checks and insulin administration need to be a priority and said the medications should have been administered as ordered with breakfast and not administered almost 1.5 hours late. The Regional Clinical Nurse said Nurse #4 is a new nurse who should have checked Resident #52's blood sugar level in the morning and should not have withheld the scheduled insulin without contacting the provider. The Regional Clinical Nurse said nurses should not stop a medication pass when critical medications like insulin are ordered and need to be administered.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure staff implemented infection control practices to decrease the risk of infection and contamination for three Residents (#59, #6 and #49) out of a total of 18 sampled residents. Specifically:1. The facility failed to ensure staff implemented Enhanced Barrier Precautions (EBP) for Resident #59 and Resident #6.2. For Resident #49 the facility failed to a. change and label oxygen and nebulizer tubing as indicated in the physician's orders and b. properly store a Bi-level positive airway pressure (BiPAP, a noninvasive ventilation device that helps patients breathe by delivering two levels of air pressure: higher during inhalation and lower during exhalation) mask.Findings include: 1a. Review of the facility policy titled Enhanced Barrier Precautions, dated April 2026 indicated: The enhanced barrier precautions (EBP) require the use of gown and gloves during high contact care activities. Examples of high contact resident care activities requiring gown and glove use among residents that trigger EBP include: dressing, bathing or showering, performing transfers, providing hygiene, changing linens, device care. Resident #59 was admitted to the facility in December 2025 with diagnoses including stroke and aphasia. Review of the Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #59 is severely cognitively impaired as evidenced by a score of four out of a possible 15 on the Brief Interview for Mental Status (BIMS) exam. The MDS also indicated that Resident #59 utilizes a feeding tube. Review of the physician orders indicated: Enhanced barrier precautions 2/2 (secondary to) wound, tube feeding site; every shift, dated 12/23/25.Review of Resident #59's Care plans indicated: Focus: Resident is on enhanced barrier precautions 2/2 abdominal wound, g tube site, 12/23/25. Interventions: Maintain Enhanced Barrier Precautions at all times. Use gown and gloves when performing high contact activities including toileting/incontinence care, dressing, bathing and showering, transferring, care of device, wound care, changing linens or any activity with close contact. Post signage outside resident's door. On 5/4/26 at 7:49 A.M., the surveyor observed Resident #59 resting in bed and with his/her tube feeding connected and running. There was a sign outside of his/her door indicating EBP. Resident #59 said he/she was uncomfortable and the surveyor alerted the nurse.On 5/4/26 at 7:50 A.M., the surveyor observed a nurse and a Certified Nursing Aide (CNA) repositioning Resident #59 in bed without wearing gowns. On 5/5/26 at 7:58 A.M., the surveyor observed Nurse #1 enter resident #59's room and adjust his/her blankets over his/her body. Nurse #1 did not wear a gown or gloves.On 5/5/26 at 9:18 A.M., Nurse #1 was observed wearing gloves and positioning Resident #59 in bed. Nurse #1 touched the buttons on the tube feed pump, adjusted Resident #59's blankets and then adjusted Resident #59's shoulder in bed. Nurse #1 was not wearing a gown. On 5/5/26 at 10:26 A.M., the surveyor observed CNA #1 providing Resident #59 a bed bath without wearing a gown.During an interview on 5/5/26 at 10:28 A.M., Nurse #1 said that she only needs to wear a gown while taking care of Resident #59's tube feeding.During an interview on 5/5/26 at 10:53 A.M., CNA #1 said that she does not have to wear a gown while bathing Resident #59, only gloves.During an interview on 5/5/26 at 10:52 A.M., Unit Manager #1 said that staff should wear a gown and gloves while providing high contact care to residents on Enhanced Barrier Precautions.During an interview on 5/5/26 at 12:12 P.M., the Director of Nursing said that staff should wear a gown and gloves while providing direct care to residents on enhanced barrier precautions. 1b. Resident #6 was admitted to the facility in April 2019 with diagnoses including stroke and cognitive communication deficit. Review of the Minimum Data Set assessment (MDS) dated [DATE] indicates that Resident #6 is severely cognitively impaired as evidenced by a score of 2 out of a possible 15 on the Brief Interview for Mental Status (BIMS) exam.On 5/4/26 at 7:52 A.M., the surveyor observed Resident #6 lying in bed. Resident #6 did not respond to the surveyors' questions. A sign outside the door indicated Enhanced Barrier Precautions. Review of Resident #6's physician order indicated: Enhanced barrier precautions, dated 2/26/26. Review of Resident #6's Wound Visit (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Note dated 4/29/26 indicated he/she had an abscess wound on his/her left hip, and skin tears on his/her left and right heels. Review of Resident #6's care plans indicated: Focus: Resident is on Enhanced Barrier Precautions 2/2 (secondary to) abscess on the left hip, 3/24/36. Interventions: Maintain Enhanced Barrier Precautions at all times. Use gown and gloves when performing high contact activities including toileting/incontinence care, dressing, bathing and showering, transferring, care of device, wound care, changing linens or any activity with close contact. Post signage outside resident's door.Focus: Resident has infection r/t (related to) abscess of the left hip, 3/24/26. Intervention: Maintain enhanced barrier precautions when providing resident care.On 5/5/26 at 10:26 A.M., the surveyor observed Certified Nursing Aide (CNA) #2 giving Resident #6 a bed bath. CNA #2 was not wearing a gown.During an interview on 5/5/26 at 10:44 A.M., CNA #2 said she does not have to wear a gown while providing care to Resident #6. During an interview on 5/5/26 at 10:52 A.N., Unit Manager #1 said that staff should wear a gown and gloves while providing high contact care to residents on Enhanced Barrier Precautions. During an interview on 5/5/26 at 12:12 P.M., The Director of Nursing (DON) said that staff should wear a gown and gloves while giving direct care to residents on enhanced barrier precautions. 2. Review of the facility policy titled Oxygen Tubing Safety and Infection Control, dated as 3/7/22, indicated the following:-Frequency of tubing change- a. Nasal Cannula tubing: changed weekly or sooner if visibly soiled. b. Nebulizer tubing (if applicable) changed according to respiratory therapy protocol or every week if in use.-Oxygen equipment must be stored in a clean, dry location when not in use.Resident #49 was admitted to the facility in October 2023 with diagnoses that included chronic obstructive pulmonary disease and obstructive sleep apnea. Review of the most recent Minimum Data Set (MDS) assessment, dated 1/29/26, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating intact cognition. The MDS failed to indicate the use of non-invasive ventilation (Bipap or CPAP) On 5/4/26 at 7:59 A.M., the surveyor observed Resident #49 sitting up in bed. There was a nebulizer mask stored in a bag labeled with a date of 4/20/26. There was an oxygen concentrator with tubing wrapped around it, unbagged, and labeled 4/20/26. The Resident also had a BiPAP machine with the tubing and mask stored inside the bedside table drawer with other belongings. During an interview on 5/4/26 at 7:59 A.M., Resident #49 said that he/she is supposed to use oxygen at night with his/her BiPAP but that he/she hasn't been able to because the concentrator hasn't been working correctly. The Resident further said he/she is using the BiPAP and nebulizers regularly. On 5/4/26 at 12:45 P.M., the surveyor observed a new concentrator had been provided to the Resident. Both the oxygen and nebulizer tubing were now labeled as 5/3/26, which was inconsistent with the surveyor's initial observation at 7:59 A.M. On 5/6/26 at 7:25 A.M. and 7:58 A.M., the surveyor observed the Resident's BiPAP mask stored on top of the bedside table, not in a bag. Review of the Resident's active plan of care indicated the following: CPAP / BiPAP Therapy- DX (diagnosis) of Obstructive Sleep Apnea, dated as revised 5/29/25. Review of physician's orders indicated the following:-Change O2 (oxygen) Tubing and Clean Filter every week on Sunday 11-7, dated 6/1/25.-BIPAP to wear at bedtime and as needed. DX: Obstructive Sleep Apnea, dated 5/29/25.-Oxygen 1-4L/min (liters per minute) (can titrate to achieve O2 sat>90%) PRN (as needed) for SOB (shortness of breath) or O2 sat<90%, dated 12/17/23.-Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML, 3 ml inhale orally four times a day related to acute respiratory failure, dated 11/10/25. Review of Resident #49's April 2026 and May 2026 Treatment Administration Record indicated nursing changed the oxygen tubing as ordered on 4/27/26 and 5/3/26, however, this was inconsistent with the surveyor's observations. During an interview on 5/6/26 at 8:05 A.M., Nurse #2 said that respiratory tubing should be changed weekly and all respiratory equipment should be stored in a bag. During an interview on 5/6/26 at 8:44 A.M., the Regional Clinical Nurse said that tubing is changed weekly. She said if it is signed off as changed, she would expect that it is completed. She further said that respiratory equipment should be stored in a bag. During an interview on 5/6/26 at 11:26 A.M., the Director of Nurses said that tubing should be changed weekly as indicated in physician's orders. She further said that respiratory equipment should be properly stored.