STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315137	A. Building B. Wing	01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Barn Hill	249 High Street Newton, NJ 07860

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and a review of the facility policies, it was determined that the facility failed to ensure that a medication was administered according to the physician orders (PO) and acceptable standards of practice in accordance with the New Jersey Board of Nursing. This deficient practice was identified in 2 of 27 residents (Resident #9 and Resident #29) observed during the medication review.The deficient practice was evidenced by the following:Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist.Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.1). On 12/29/2025 11:46 AM, The surveyor observed Resident #9 who was alert and oriented sitting in bed and was watching television.A review of the admission Record (an admission summary) reflected that Resident #9 was admitted to the facility with diagnoses that included malignant neoplasm of bladder (bladder cancer), gross hematuria(the visible presence of blood in the urine, making it appear pink, red, colored, or brownish), and chronic kidney disease (a progressive condition where kidneys gradually lose their ability to filter waste and fluids from the blood).A review of the Quarterly Minimum Data Set, an assessment tool used to facilitate the of care, dated 10/10/25, reflected that the resident's cognitive skills for daily decision-making score was 15 out of 15, which indicated that the resident was cognitively intact.A review of a Physician order dated 12/17/25 and signed by the physician revealed an order for Macrobid 100 mg (antibiotic for a urinary tract infection) to be given twice daily for 5 days.A review of the December 2025 Order Summary Report (OSR) revealed the following Physician's Order (PO) dated 12/17/25 for Macrobid oral capsule 100 mg (Nitrofurantoin Monohydrate Macro) give 100 mg by mouth two times a day for Urinary Tract Infection (UTI) with no stop date. A review of the December 2025 and January 2026 electronic medication administration record (e-MAR) revealed a PO dated 12/17/25 for Macrobid Oral Capsule 100 mg, give 100 mg by mouth two times a day for UTI (no stop date). A further review of the resident's e-MAR revealed that the medication had an administration time of 0900 (9:00AM) and 2100 (9:00PM) and was plotted as being administered from 12/17/25 through 1/5/26.On 1/5/26 at 9:30 AM, the surveyor in the presence of the Licensed Practical Nurse (LPN#1) reviewed Resident #9's medical records and LPN#1 acknowledged that the resident has a standing order for Macrobid 100 mg because the resident is being seen by the urologist weekly. When the surveyor asked the LPN#1 to review the PO dated (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/17/25, she acknowledges that the order was written by the physician and that the order for Macrobid was written for 5 days. Both LPN#1 and the Registered Nurse (RN)/unit manager acknowledge that the order should have been verified with the physician.2).12/29/25 at 10:45 AM, the surveyor observed Resident #29 who was seated on their bed and was watching television. The resident was alert and oriented and told the surveyor in an interview that he/she receives their medications every day.A review of the admission Record (an admission summary) reflected that Resident #29 was admitted to the facility with diagnoses that included peripheral vascular disease(a circulation disorder where narrowed blood vessels (usually in the legs/arms) reduce blood flow, causing pain, cramping, or fatigue), chronic diastolic (congestive) heart failure(occurs when the left ventricle stiffens and can't relax properly to fill with enough blood between beats, leading to fluid backup (congestion) in the lungs and body, causing symptoms like shortness of breath, fatigue, and swelling), and atherosclerotic heart disease (caused by plaque buildup in arterial walls).A review of the admission Minimum Data Set, dated [DATE], reflected that the resident's cognitive skills for daily decision-making score was 15 out of 15, which indicated that the resident was cognitively intact.A review of the December 2025 OSR revealed the following PO dated 10/02/25 for Metoprolol Succinate ER tablet Extended Release 24 hour 25 mg, give 1 tablet by mouth one time a day for Hypertension (HTN) hold for Systolic Blood Pressure (SBP) (a top, higher number in a blood pressure reading, measuring the pressure in your arteries when your heart beats (contracts) and pushes blood out) less than or equal to 90 and/ or heart rate (HR) (how many times your heart beats per minute) less than or equal to 60A review of the October, November, and December 2025, e-MAR revealed a PO dated 10/02/25 for Metoprolol Succinate ER tablet Extended Release 24-hour 25 mg, give 1 tablet by mouth one time a day for Hypertension (HTN) hold for SBP less than or equal to 90 and/or HR less than or equal to 60. The e-MAR further revealed that Metoprolol Succinate ER had a plotted time of 0800 (8:00 AM) and contained no dropped down to enter the resident's HR or BP (blood pressure). The e-MAR further revealed from 10/2/25 through 12/30/25 that the nurses were only documenting that the medication was being administered with no heart rate or blood pressure. The e-MAR also revealed that from 10/2/25 through 12/30/25 that the resident received Metoprolol Succinate ER 25 mg every day and was never held in that period.A review of the electronic medical record under weights and vitals revealed an entry section for blood pressure (BP) and pulse (heart rate) which showed that both the resident's BP and HR were not being monitored every day at 0800 (8:00AM).On 12/30/25 at 12:25 PM, the surveyor in the presence of LPN#1 reviewed the resident's physician's orders and e-MAR. LPN#1 acknowledge that the resident had an order for Metoprolol Succinate ER to hold the medication when the resident's SBP was equal or less than 90 or when the resident's HR was equal or less than 60. LPN#1 further acknowledge after reviewing the resident's e-MAR that the resident's SBP and HR was not being documented, and that the e-MAR should have a drop down do that both the HR and BP could be monitored.On 01/2/26 at 12:30 PM and on 01/5/26 at 10:00 AM, the surveyor discussed the above concerns to the facility administration team that consisted of the Licensed Nursing Home Administrator, the Director of Nursing (DON), Regional Nurse, and the Director of Operations.There was no additional information provided.A review of the facility's policy for Following Physician Orders that was dated 10/1/25 and was provided by the Director of Operations revealed the following: 2. Medications must be administered in accordance with the orders, including any required time frame. 6. The following information must be checked/verified for each resident prior to administering medications: a. allergies to medications; and b. vital signs, if necessary.A review of the facility's policy for Medication Administration that was dated 9/1/25 and was provided by the Director of Operations revealed the following: 8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters. 21. Sign MAR after administered. For those medications requiring vital signs, record vital signs onto the MAR.NJAC 8:39-11.2 (b), 29.2 (d)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on observation, interview, and record review, it was determined that the facility failed to respond to the Consultant Pharmacist's (CP) monthly recommendations in a timely manner for 1 of 27 residents (Resident #29) reviewed.The deficient practice was evidenced by the following:On 12/29/25 at 10:45 AM, the surveyor observed Resident #29 who was seated on their bed and was watching television. The resident was alert and oriented and told the surveyor in an interview that he/she received their medications every day.A review of the admission Record (an admission summary) reflected that Resident #29 was admitted to the facility with diagnoses that included peripheral vascular disease(a circulation disorder where narrowed blood vessels (usually in the legs/arms) reduce blood flow, causing pain, cramping, or fatigue), chronic diastolic (congestive) heart failure(occurs when the left ventricle stiffens and can't relax properly to fill with enough blood between beats, leading to fluid backup (congestion) in the lungs and body, causing symptoms like shortness of breath, fatigue, and swelling), and atherosclerotic heart disease (caused by plaque buildup in arterial walls).A review of the admission Minimum Data Set, an assessment tool used to facilitate the of care, dated 09/09/25, reflected that the resident's cognitive skills for daily decision-making score was 15 out of 15, which indicated that the resident was cognitively intact.A review of the December 2025 Order Summary Report (OSR) revealed the following Physician's Order (PO) dated 10/02/25 for Metoprolol Succinate ER tablet Extended Release 24 hour 25 mg, give 1 tablet by mouth one time a day for Hypertension (HTN) hold for Systolic Blood Pressure (SBP) (a top, higher number in a blood pressure reading, measuring the pressure in your arteries when your heart beats (contracts) and pushes blood out) less than or equal to 90 and/ or Heart rate (HR) (how many times your heart beats per minute) less than or equal to 60A review of the October, November, and December 2025, e-MAR revealed a PO dated 10/02/25 for Metoprolol Succinate ER tablet Extended Release 24-hour 25 mg, give 1 tablet by mouth one time a day for Hypertension (HTN) hold for SBP less than or equal to 90 and/or HR less than or equal to 60. The e-MAR further revealed that Metoprolol Succinate ER had a plotted time of 0800 (8:00 AM) and contained no dropped down to enter the resident's HR or BP (blood pressure). The e-MAR further revealed from 10/2/25 through 12/30/25 that the nurses were only documenting that the medication was being administered with no heart rate or blood pressure. The e-MAR also revealed that from 10/2/25 through 12/30/25 that the resident received Metoprolol Succinate ER 25 mg every day and was never held in that period.A review of the electronic medical record under weights and vitals revealed an entry section for blood pressure (BP) and pulse (heart rate) which showed that both the resident's BP and HR were not being monitored every day at 0800 (8:00AM).A review of the CP - Medication Regimen Review revealed the following recommendations:A CP recommendation dated 10/21/25 which revealed the following: Metoprolol has hold parameters that are not being properly followed. Please re-enter order requiring BP and pulse to be taken and inputted into the e-MAR prior to administering medication (check off supplementary documentation for BP and Pulse). The recommendation had noted under the response section.A CP recommendation dated 12/19/25 which revealed the following Metoprolol has hold parameters that are not being properly followed. Please re-enter order requiring BP and Pulse to be taken and inputted into the e-MAR prior to administering medication (check off supplementary documentation for BP and Pulse. The recommendation had completed under the response section. On 1/5/26 at 10:10 AM, the surveyor interviewed the Director of Nursing (DON) regarding who would review and sign the response section of the CP recommendation. DON stated that the unit manager would be the one who would review and sign off the CP recommendations. She stated that when the unit manager wrote complete, they are acknowledging that the recommendation is being address. the DON further stated that it was the unit managers responsibility that the recommendations are being followed through. On 1/05/26 at 10:15 AM, the surveyor discussed the above concerns with the facility administrative team which (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	consisted of the Licensed Nursing Home Administrator, Director of Nursing, Regional Nurse, and the Director of Operations.No further information was provided. A review of the facility's policy Pharmacy Services provided by the Director of Operations with a date of 9/1/2025, did not include a section regarding a facility's response to the CP recommendations pertaining to medication irregularities. NJAC 8:39-29.3

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain the call bell within reach of residents. This deficient practice was identified for 3 of 27 residents reviewed for accommodation of needs (Resident #16, 80, and 101), and was evidenced by the following: 1. On 12/29/2025 at 10:50 AM, the surveyor observed Resident #101 in bed with their eyes open and the call bell (a device used to summon the staff for assistance) on the floor, not within the resident's reach.The surveyor reviewed the medical record for Resident #101. A review of the admission Record reflected the Resident was admitted to the facility with diagnoses that included but were not limited to; dementia, (a broad term covering various brain conditions that affect thinking, memory and behavior), Parkinson's disease (a degenerative brain disorder that damages dopamine-producing neurons) and diabetes mellitus (a disease of inadequate control of blood levels of glucose). A review of Resident #101's quarterly Minimum Data Set (MDS), an assessment tool dated 10/31/25, revealed Resident #101 had a Brief Interview for Mental Status (BIMS) score of 8 out of 15, which indicated the resident had a moderate cognitive impairment. The MDS further revealed that Resident #101 required staff assistance with activities of daily living (ADL). A review of Resident #101's Individualized Care Plan (CP) had a focus that indicated the resident had an ADL self-care performance deficit related to Parkinson's disease, with interventions that included but were not limited to; encourage the resident to use the call bell for assistance. 2. On 12/29/2025 at 11:00 AM, the surveyor observed Resident #16 in bed on a specialty mattress, with oxygen infusing at 2.5 Liters per minute via nasal cannula tubing. The surveyor observed that the call bell was behind Resident #16's privacy curtain on their roommate's table, not within the Resident's reach. The surveyor reviewed the medical record for Resident #16. A review of the admission Record reflected the Resident was admitted to the facility with diagnoses that included but were not limited to; dementia, hypertension (high blood pressure, a condition where the force of blood against artery walls is too high, making the heart work harder) and coronary artery disease (a narrowing or blockage of coronary arteries, which supply oxygenated blood to the heart.) A review of Resident #16's quarterly MDS dated [DATE] revealed Resident #16 had a BIMS score of 00 out of 15, which indicated the resident had a severe cognitive impairment. The MDS further revealed that Resident #16 was dependent on staff for ADL care. A review of Resident #16's CP had a focus that indicated the resident was at risk for falls, with interventions that included but were not limited to: ensuring that when the resident was in bed, all personal items were within their reach.3. On 12/29/25 at 11:05 AM, the surveyor observed Resident #80 in bed. The surveyor observed the call bell on the floor, under the bed frame, not within the resident's reach. The surveyor reviewed the medical record for Resident #80. A review of the admission Record reflected the Resident was admitted to the facility with diagnoses that included but were not limited to; Alzheimer's Disease (a progressive brain disease causing dementia). A review of Resident #80's annual MDS dated [DATE] revealed Resident #80 had a BIMS score of 00 out of 15, which indicated the resident had a severe cognitive impairment. The MDS further revealed that Resident #80 was dependent on staff for ADL care. A review of Resident #80's CP had a focus that indicated the resident was at risk for falls, with interventions that included but were not limited to; anticipate and meet the resident's needs and encourage the resident to participate in activities. On 12/30/25 at 11:15 AM, during an interview with the surveyor, the Licensed Practical Nurse/Unit Manager (LPN/UM) confirmed that nurses and Certified Nursing Assistants should make frequent rounds to ensure that when residents were in bed, their call bells were placed within reach. On 12/30/25 at 11:20 AM, during an interview with the surveyor, the Program Director confirmed that all residents should have their call bells within reach. On 1/2/26 at 12:44 PM, the survey team met with the Director of Nursing (DON), Licensed Nursing Home Administrator (LNHA), and [NAME] President of Operations (VPO) to discuss the above observations and concerns. A review of the facility's Call (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Light: Accessibility and Timely Response dated 9/1/25 reflected.The purpose of this policy is to ensure the facility is adequately equipped with a call light at each resident's bedside, toilet, and bathing facility to allow residents to call for assistance. The call system will be accessible to residents while in their beds. NJAC 8:39-27.1 (a); 31.8 (c) (9)

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of the facility policy, it was determined that the facility failed to provide a homelike environment in resident rooms. The deficient practice was observed on 1 of 5 units ([NAME] Unit). The deficient practice was evidenced by the following:On 12/31/25 at 9:30 AM, the surveyor toured the [NAME] nursing unit and observed the following: In room [ROOM NUMBER], the floor was discolored and had black smudge marks throughout.In room [ROOM NUMBER], the floor was discolored and soiled, with black smudge marks throughout.In room [ROOM NUMBER], the wall across from the door, by the bed, was cracked, exposing wallboard, and the floor was discolored.In room [ROOM NUMBER], the floor was stained and soiled with a brownish substance, with black smudge marks throughout.In room [ROOM NUMBER], the wall across from the door and window bed was soiled with chipped paint and exposed wallboard.In room [ROOM NUMBER], molding was missing across the entire wall, and cracks exposed the wallboard. Floor heavily stained with brown substance and black smudge marks throughout.In room [ROOM NUMBER], the wall across from the bed, near the door, had chipped paint revealing exposed wallboard, and the floor was heavily stained with a brown substance. On 12/31/25 at 9:45 AM, during an interview with the surveyor, the maintenance floor technician acknowledged that the floors needed to be cleaned, waxed, buffed, and/or replaced. On 1/2/25 at 9:00 AM, the surveyor presented the above concerns to the director of maintenance/housekeeping (DOM/H). The DOM/H confirmed that the above conditions were not conducive to a clean, homelike environment and that the floors needed to be deep-cleaned, stripped, and waxed or replaced, and the walls needed to be repaired. On 1/2/26 at 12:44 PM, the survey team met with the Director of Nursing (DON), Licensed Nursing Home Administrator (LNHA), and [NAME] President of Operations (VPO) to discuss the above observations and concerns. A review of the facility's policy, Safe and Homelike Environment, dated as reviewed 9/1/25, reflected .In accordance with residents' rights, the facility will provide a safe, clean, comfortable, and homelike environment . On 1/5/25 at 11:30 AM, the survey team met with the DON, LNHA, VPO and Regional DON. No further information was provided. NJAC 8:39-4.1(a)11. 31.4 (a), (b), (c), (f)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to administer Oxygen therapy according to the physician's orders for 2 of 3 residents reviewed for Respiratory therapy, Resident #16 and #53. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. 1. On 12/29/2025 at 11:00 AM, the surveyor observed Resident #16 in bed on a specialty mattress, with Oxygen (O2) delivered via a nasal cannula (NC) tubing attached to the O2 concentrator at 2.5 Liters per minute (LPM). On 12/30/25 at 11:05 AM, the surveyor observed Resident #16 in bed on a specialty mattress, with O2 delivered via a NC tubing attached to the O2 concentrator at 2.5 Lpm. The surveyor reviewed the medical record for Resident #16. A review of the admission Record reflected the Resident was admitted to the facility with diagnoses that included but were not limited to; dementia (loss of mental functioning), hypertension (high blood pressure, a condition where the force of blood against artery walls is too high, making the heart work harder) and coronary artery disease (a narrowing or blockage of coronary arteries, which supply oxygenated blood to the heart.) A review of Resident #16's quarterly MDS dated [DATE] revealed Resident #16 had a BIMS score of 00 out of 15, which indicated the resident had a severe cognitive impairment. The MDS further revealed that Resident #16 was dependent on staff for ADL care, and section O indicated that the resident received special respiratory treatments, which included O2 therapy. A review of Resident #16's Care Plan had a focus that indicated the resident exhibited or was at risk for cardiovascular symptoms or complications related to diagnoses of hypertension and coronary artery disease, with interventions that included but were not limited to; Resident uses O2 at 3 LPM via NC. A review of the current Order Summary Report reflected a Physician's Order (PO) for O2 at 3 LPM via NC tubing continuously every shift with a start date of 09/06/2023. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/30/25 at 11:10 AM, the surveyor showed the Licensed Practical Nurse (LPN #1) assigned to Resident #16's care the O2 flow rate. LPN #1 confirmed that the gauge was set at 2.5 LPM but should have been set at 3 LPM per the Physician's orders. LPN #1 further stated that she usually checked the O2 gauge each morning, but had not checked it that morning. 2. On 12/29/25 at 11:00 AM, the surveyor observed Resident #53 in bed with their eyes closed. Resident #53 was further observed receiving O2 via NC currently running at 3 LPM. On 12/29/25 at 11:25 AM, the surveyor reviewed Resident #53's medical record, which revealed the following:The surveyor reviewed the admission Record which revealed that the resident had been admitted to the facility with diagnoses that included chronic kidney disease (progressive damage and loss of kidney function), chronic atrial fibrillation (irregular heartbeat that may cause the heart to beat faster than usual), and cardiomyopathy (disease of the heart muscle). A review of the admission MDS, dated [DATE], revealed that the resident had a BIMS score of 8 out of 15, which indicated moderate cognitive impairment. The MDS also reflected that the resident received continuous O2 therapy. A review of Resident #153's CP had a focus that indicated respiratory therapy for improvement in pulmonary function related to poor lung expansion; the CP did not include interventions for following the physician's orders for O2 administration. A review of the December 2025 PO for Resident #53 included a PO dated 12/2/25, Oxygen at 2 L/min via Nasal Cannula every shift for hypoxia. On 1/2/26 at 9:11 AM, in the presence of LPN#2, the surveyor observed Resident #53's O2 machine set at 2.5 LPM. LPN#2 stated Resident #53 was on continuous O2 at 2 L/min; unable to state why the O2 was set at 2.5 LPM. On 1/2/26 at 11:35 AM, the Director of Nursing (DON) provided the surveyor with a facility policy titled, Oxygen Concentrator, with a reviewed date of 9/1/25 .The policy explanation section revealed, 4.a. The nurse shall verify the physician's orders for the rate of flow and route of administration of oxygen. Plug the unit in and turn the unit on to the desired flow rate. On 1/2/26 at 12:43 PM, the surveyor met with the DON, Licensed Nursing Home Administrator (LNHA), and [NAME] President of Operations (VPO) to review concerns identified during the survey. The DON stated that all O2 settings should match the PO. On 1/5/26 at 11:37 AM, the survey team met with the DON, LNHA, VPO, and Regional Director of Nursing (RDON) for the exit conference. No further pertinent information provided. NJAC 8:39- 27.1 (a)