STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335243	A. Building B. Wing	10/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Park Rehabilitation and Nursing Center	330 Chestnut Street Oneonta, NY 13820

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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
	335243	A. Building B. Wing	10/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Park Rehabilitation and Nursing Center	330 Chestnut Street Oneonta, NY 13820

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interviews and record review conducted during the abbreviated survey (Case # 2635234), the facility did not thoroughly investigate accidents for 1 (one) of 4 (four) residents reviewed for accidents. Specifically, on 9/28/2025 at 11:30 PM, Resident #1 was found in their room on the floor next to their bed. Resident #1 was unresponsive except to painful stimuli and had uncontrollable shaking. Resident #1 was left for an undetermined amount of time without providing care. Subsequently, when assessing Resident #1's vital signs (key indicators of the body's essential physiological functions including temperature, heart rate, breathing rate, and blood pressure), Resident #1's body temperature was too low to be read by a thermometer. The facility did not have documented evidence of a thorough investigation to rule out if Resident #1 was abused and/or neglected.This is evidenced by:Cross-referenced to F689: Free of Accident Hazards/Supervision/DevicesThe Policy and Procedure titled, Accident and Incident-Investigating and Reporting-Resident, reviewed 01/2025, documented all accidents or incidents involving residents occurring on the premises would be investigated and reported to the Administrator. The following data, as applicable, would be included on the Report of Incident/Accident form: the date and time the accident or incident took place; the nature of the injury/illness; the circumstances surrounding the accident or incident; where the accident or incident took place; the condition of the injured person, including their vital signs; other pertinent data as necessary or required. The Policy and Procedure titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, reviewed 01/2025, documented residents had the right to be free from abuse and neglect. Implementation of the policy and procedure consisted of a facility-wide commitment and resource allocation to support the following objectives: develop and implement policies and protocols to prevent and identify abuse or mistreatment of residents, neglect of residents and to identify and investigate all possible incidents of abuse and neglect.Resident #1 was admitted to the facility with diagnoses of unspecified dementia without behavioral/psychotic/mood disturbance (a condition where a person experiences cognitive decline [memory loss, confusion, difficulty with thinking and reasoning] but the specific cause of the decline cannot be determined), history of falling, and generalized anxiety disorder (excessive, ongoing anxiety and worry that are difficult to control and interfere with day-to-day activities). The Minimum Data Set (an assessment tool) dated 07/17/2025, documented the resident had severe cognitive impairment. The resident was able to make themselves understood and understand others. Incident and Accident Statement Form completed on 09/28/2025 by Certified Nurse Aide #1 documented on 09/28/2025 at 11:30 PM, they walked by Resident #1's room, looked in and saw Resident #1 on the floor between their bed and the window. This statement documented the last time Resident #1 was toileted or changed was on 09/28/2025 at 8:30 PM. On 09/28/2025 at 11:30 PM, an Accident/Incident Report by Licensed Practical Nurse #1 documented Resident #1 was found lying on the floor between their bed and the wall. The resident was noted with their head at the foot of the bed. Resident #1 was responsive only to vigorous stimulation and not to verbal stimuli. Vital signs and neurological checks were attempted but unsuccessful. The thermometer was unable to read the temperature of the resident. Staff attempted to obtain a blood pressure with the machine as well as manually but was unable to obtain due to the resident shaking. Summary of Investigation Report dated 09/29/2025 documented on 09/28/2025 at 11:30 PM, Resident #1 was found in their room after an unwitnessed fall from their bed to the floor. There was a small skin tear on their left elbow and a bump on the left back of their head. Resident #1's temperature was unreadable. Was unable to determine the blood pressure. Heart rate was 115. Oxygen saturation level was 73 percent ‘but may be inaccurate due to how cold the resident was.' The summary further documented that Resident #1 was sent to the Emergency Department and admitted to the hospital with changes in mental status. The Summary of Investigation Report did not include an investigation of the amount of time Resident #1 was on the floor or factors that contributed to why Resident #1 was cold and their body temperature was unreadable. Physician progress note dated 09/28/2025 at 11:47 PM documented nursing staff noted Resident #1 had an unwitnessed fall. They were found sitting on the floor next to their bed. It appeared the resident slid out of the bed and on to the floor. Body check was performed. No visible injuries. No open wounds or abrasions. Resident was unreliable to tell whether they had a head strike. Nursing staff noted the resident was holding their head. No mental status changes. The resident was not on any systemic anticoagulation (medical treatment that prevents blood clots from forming or growing). Vital signs were stable.There was no documented evidence in the Investigation Report that addressed the discrepancies between the Physician progress note dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335243	A. Building B. Wing	10/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Park Rehabilitation and Nursing Center	330 Chestnut Street Oneonta, NY 13820

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335243	A. Building B. Wing	10/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Park Rehabilitation and Nursing Center	330 Chestnut Street Oneonta, NY 13820

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during an abbreviated survey (Case # 2635234), the facility did not ensure the development and implementation of a person-centered care plan that included measurable objectives and timeframes to meet the resident's needs for 2 (two) (Resident #s 1 and 3) of 4 (four) residents reviewed. Specifically, the facility did not ensure it developed, implemented, monitored, and evaluated appropriate person-centered care plan interventions to mitigate falls for Resident #'s 1 and 3, who had multiple unwitnessed falls in their rooms related to self-ambulation. This is evidenced by: Cross-referenced to F689: Free of Accident Hazards/Supervision/Devices The Policy and Procedure titled, Falls and Fall Risk Managing, reviewed 1/2025, documented that based on previous evaluations and current data, staff must identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. If falling reoccurred despite initial interventions, staff would implement additional or different interventions or indicate why the current intervention remained appropriate. If underlying causes could not be readily identified or corrected, staff would try various interventions, based on the assessment of the nature or category of falling, until falling was reduced or stopped, or until the reason for the continuation of the falling was identified as unavoidable. The policy required documentation of ongoing monitoring and evaluation of each resident's response to interventions. If the resident continued to fall, staff would re-evaluate the situation and whether it was appropriate to continue or change current interventions. The policy documented physician involvement when falls persisted. The Policy and Procedure titled, Falling Star Program, reviewed 1/2025, documented that the program identified residents at highest risk for falls and required aggressive monitoring and prevention of injury related to falls. The policy documented that staff were to place a star symbol near the resident's room nameplate, and on the resident's walker or wheelchair, to indicate high fall risk. Staff were to be informed of residents enrolled in the program during shift-to-shift report and rounds. The policy specified that residents demonstrating unsafe behaviors or repeated falls required increased staff awareness and monitoring wherever they were in the facility. Resident #1: Resident #1 was admitted to the facility with diagnoses of unspecified dementia without behavioral/psychotic/mood disturbance (a condition where a person experiences cognitive decline [memory loss, confusion, difficulty with thinking and reasoning] but the specific cause of the decline cannot be determined), history of falling, and generalized anxiety disorder (excessive, ongoing anxiety and worry that are difficult to control and interfere with day-to-day activities). The Minimum Data Set (an assessment tool) dated 7/17/2025, documented the resident had severe cognitive impairment. The resident was able to make themselves understood and understand others. The Discharge Minimum Data Set, dated [DATE], documented the resident's height was 63 inches and weight was 164 pounds, a body mass index (BMI) of 29. 0 classified as overweight. Review of Care Plan titled, At Risk for Functional Decline in Mobility and Self Care related to age related changes, dementia, and benign prostatic hyperplasia (enlarged prostate), revised 7/2/2025, documented the resident had a history of self-transferring. Interventions included encouraging use of the call bell, providing partial assistance for transfers, and ensuring assistive devices were within reach. Review of Care Plan titled, At Risk for Falls related to history of falls, and age-related changes including cataracts, revised 6/12/2025, documented interventions included but were not limited to 'anticipate and meet resident's needs' and bed in lowest position. Review of Care Plan titled, Resident had an Actual Fall related to cognitive deficit, gait/balance problems, history of falls, poor communication/comprehension, revised 9/29/2025, documented five (5) unwitnessed falls related to self-transferring: 7/07/2025 at 8:45 AM; 8/24/2025 at 8:30 PM; 9/22/2025 at 4:10 PM; 9/24/2025 at 5:15 PM; 9/28/2025 at 11:30 PM. Interventions after each fall were limited to environmental reminders (example: a 'Call Do Not Fall' sign, flat call bell). There was no documented evidence in Resident #1's comprehensive care plan, of the development, implementation, monitoring, and evaluation of appropriate person-centered care plan interventions to mitigate falls. During an interview on 10/08/2025 at 10:20 AM, Licensed Practical Nurse #3 stated Resident #1 would not use the call bell; the call bell was flat, and the resident was able to demonstrate its use. During an interview on 10/08/2025 at 1:19 PM, Licensed Practical Nurse #2 stated they worked the evening shift on 9/28/2025 and Resident #1 was on their assignment. Resident #1 was a frequent faller. During an interview on 10/08/2025 at 4:01 PM, Physician #1 stated that a person with frequent falls should be checked often. During an interview on 10/08/2025 at 5:15 PM, Administrator #1 stated Resident #1 had several falls

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335243	A. Building B. Wing	10/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Park Rehabilitation and Nursing Center	330 Chestnut Street Oneonta, NY 13820

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335243	A. Building B. Wing	10/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Park Rehabilitation and Nursing Center	330 Chestnut Street Oneonta, NY 13820

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during an abbreviated survey (Case #2635234), the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for two (2) of four (4) residents (Resident #1 and 3) reviewed for falls. Specifically, [a.] Resident #1 had severe cognitive impairment and had five (5) unwitnessed falls from [DATE] to [DATE]. The facility failed to develop appropriate interventions to mitigate falls when it was known that the resident was self-transferring. On [DATE] at 11:30 PM, Resident #1 was found on the floor unresponsive, unclothed and cold to the touch by Certified Nurse Aide #1. The resident's body temperature was unmeasurable on a facility thermometer, their oxygen saturation level was 73 percent (normal oxygen saturation levels are 95-100 percent), and they were sent to the hospital with symptoms consistent with hypothermia (occurs when core body temperature drops below 95 degrees Fahrenheit and is a medical emergency). Resident #1 expired on [DATE]. Cause of death was septic shock, pneumonia, acute hypoxic respiratory failure and encephalopathy (a change in brain function due to injury or disease). [b.] Resident #3 had moderate cognitive impairment, Parkinson's disease (movement disorder of the nervous system), and sustained 30 falls from [DATE] to [DATE], of which 20 were documented as unwitnessed. On [DATE] at 3:00 AM, Resident #3 was found crawling on the floor in their room and sustained a left wrist fracture (bone break). The facility was aware these residents were self-ambulating and did not implement appropriate interventions or provide supervision to mitigate falls. This resulted in Substandard Quality of Care, with actual harm, that was Immediate Jeopardy with the likelihood for serious adverse outcome to 23 residents identified at risk for falls.This is evidenced by:Cross-referenced to F695: Respiratory/Tracheostomy Care and Suctioning, F656: Develop/Implement Comprehensive Care Plan. The Policy and Procedure titled, Falling Star Program, reviewed 01/2025, documented that the program identified residents at highest risk for falls and required aggressive monitoring and prevention of injury related to falls. The policy documented that staff were to place a star symbol near the resident's room nameplate, and on the resident's walker or wheelchair, to indicate high fall risk. Staff were to be informed of residents enrolled in the program during shift-to-shift report and rounds. The policy specified that residents demonstrating unsafe behaviors or repeated falls required increased staff awareness and monitoring wherever they were in the facility.The Policy and Procedure titled, Falls and Fall Risk Managing, reviewed 01/2025, documented that based on previous evaluations and current data, staff must identify interventions related to the resident's specific risks and causes of falls. The policy required that when falls recurred, staff would implement additional or different interventions or justify why current interventions remained appropriate. It further directed that if underlying causes were not readily identified, staff would 'try various interventions until falling was reduced or stopped.' The policy required documentation of ongoing monitoring and evaluation of each resident's response to interventions, and physician involvement when falls persisted. Resident #1:Resident #1 was admitted to the facility with diagnoses of unspecified dementia without behavioral/psychotic/mood disturbance (a condition where a person can experience memory loss, confusion, difficulty with thinking and reasoning), history of falling, and generalized anxiety disorder (excessive, ongoing worry that are difficult to control and interfere with day-to-day activities). The Minimum Data Set (a resident assessment tool) dated [DATE], documented the resident had severe cognitive impairment. The resident was able to make themselves understood and understand others. Review of Care Plan titled, At Risk for Functional Decline in Mobility and Self Care related to age related changes, dementia, and benign prostatic hyperplasia (enlarged prostate), revised [DATE], documented the resident had a history of self-transferring. Interventions included encouraging use of the call bell, providing partial assistance for transfers, and ensuring assistive devices were within reach.Review of Care Plan titled, At Risk for Falls related to history of falls, and age-related changes including cataracts, revised [DATE], documented interventions included but were not limited to anticipate and meet resident's needs and bed in lowest position. Review of Care Plan titled, Resident had an Actual Fall related to cognitive deficit, gait/balance problems, history of falls, poor communication/comprehension, revised [DATE], documented five (5) unwitnessed falls related to self-transferring: [DATE] at 8:45 AM; [DATE] at 8:30 PM; [DATE] at 4:10 PM; [DATE] at 5:15 PM; [DATE] at 11:30 PM. Interventions after each fall were limited to environmental reminders (example: a 'Call Do Not Fall' sign, flat call bell). There was no documented evidence of new or updated interventions. During an interview on [DATE] at 11:08 AM, Licensed Practical Nurse #1 stated Resident #1 required assistance with transfers

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335243	A. Building B. Wing	10/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Park Rehabilitation and Nursing Center	330 Chestnut Street Oneonta, NY 13820

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 0695 Level of Harm - Actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335243	A. Building B. Wing	10/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Park Rehabilitation and Nursing Center	330 Chestnut Street Oneonta, NY 13820

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 0695 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview conducted during an abbreviated survey (Case #2635234), the facility did not ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences for one (1) of four (4) residents (Resident #1) reviewed. Specifically, on [DATE] at 11:30 PM, Resident #1 was found unresponsive with an oxygen saturation of 73 percent (normal 95 to100 percent) and signs of respiratory distress. Emergency Medical Services documented 'extreme' wheezing in all lung fields and a clinical impression of pneumonia (an infection in one or both lungs). The resident was admitted to the hospital with septic shock (a progression from sepsis that causes a dramatic drop in blood pressure that can damage the lungs, kidneys, liver and other organs. When the damage is severe, it can lead to death) secondary to pneumonia/acute hypoxic respiratory failure (a medical condition characterized by a rapid decline in oxygen level in the blood leading to inadequate oxygen delivery to the body's tissues) and encephalopathy (a change in brain function due to injury or disease). Resident #1 was pronounced dead on [DATE] at 11:50 PM. The cause of death was listed as septic shock, pneumonia, acute hypoxic respiratory failure, and encephalopathy. This resulted in actual harm to Resident #1 that was not Immediate Jeopardy. This is evidenced by: Cross-referenced to F689: Free of Accidents Hazards/Supervision/Devices; F656: Develop/Implement Comprehensive Care Plan The Policy and Procedure titled, Administering Medications through a Small Volume Nebulizer (a handheld medical device that converts liquid medication into a fine mist, allowing it to be directly inhaled into lungs), revised 01/2025, documented the purpose of the procedure was to safely and aseptically administer aerosolized particles of medication into the resident's airway. General Guidelines documented to follow the medication administration guidelines and document in residents medical record condition prior, during, and after administered treatment. Policy and Procedure titled, Administering Medications, reviewed 01/2025, documented medications would be administered in a safe and timely manner, and as prescribed. The Policy and Procedure titled, Acute Condition Changes - Clinical Protocol, revised 01/2025, Assessment and Recognition documented direct care staff would report and assess within their scope, any change in condition to Attending Physician. The Attending Physician would identify and authorize appropriate treatments, including authorize transfer to hospital if needed. The Policy and Procedure titled 24-Hour Report, revised 08/2025, documented the 24-hour Report outlined documentation, communicating, and follow up on significant resident care events that occurred during a 24-hour period. Resident #1 was admitted to the facility with diagnoses of unspecified dementia without behavioral/psychotic/mood disturbance (a condition where a person can experience memory loss, confusion, difficulty with thinking and reasoning), history of falling, and generalized anxiety disorder (excessive, ongoing worry that is difficult to control and interferes with day-to-day activities). The Minimum Data Set (a resident assessment tool) dated [DATE], documented the resident had severe cognitive impairment. The resident was able to make themselves understood and understood others. Record review of facility document titled, admission Record (Face Sheet), printed on [DATE], documented information as wheezing with an onset date of [DATE]. Review of Comprehensive Care Plans revealed: -Care Plan for At Risk for/has an Alteration in Respiratory Function related to (cause not documented), was initiated on [DATE] and resolved on the same day, [DATE]. There were no interventions documented. -There was no documented evidence a comprehensive care plan was created for respiratory care and services for the management of the resident's diagnosis of wheezing and that the resident was ordered to have nebulizer treatments as needed for shortness of breath or wheezing. -Care Plan for Nutritional Problem or Potential Nutritional Problem, documented and revised [DATE], included wheezing as one of the relational causes. Interventions documented were related to the resident's nutritional needs. Order Listing Report for order date range [DATE] to [DATE], documented: - Order dated [DATE] for Ipratropium 0.5 milligrams/Albuterol Solution 3 milligrams (Duoneb) 3 milliliter vial, inhale orally every four (4) hours as needed for shortness of breath or wheezing related to wheezing via nebulizer. - Order dated [DATE] for Ipratropium 0.5 milligram/Albuterol Solution 3 milligrams (Duoneb) 3 milliliter inhaled orally one (1) time only for wheezing. Physician's Progress Note dated [DATE] at 9:47 PM by on-call Nurse Practitioner #2, documented a late entry note. Subjective findings documented the registered nurse called because the resident was complaining of shortness of breath. Objective findings documented blood pressure 86 over 63, oxygen saturation 97 percent, and