STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366306	A. Building B. Wing	03/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Oaks Care Center	500 Selfridge Street East Liverpool, OH 43920

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and facility policy review, the facility failed to ensure proper sanitation and food storage practices. This had the potential to effect all 38 residents (#01, #02, #03, #04, #05, #06, #07, #08, #09, #10, #11, #13, #15, #17, #18, #19, #20, #23, #24, #25, #26, #27, #28, #29, #32, #34, #36, #37, #38, #39, #40, #42, #43, #45, #46, #47, #55, #56) who ate food from the facility kitchen. The facility census was 43.Findings include:Observation on 03/16/26 at 10:30 A.M., the walkˆin freezer contained undated breadsticks stored in an unmarked clear bag. The dry storage area contained multiple food items open to air, not sealed, and not dated, including: a two pound three ounce bag of Corn Flakes, a two pound three ounce bag of Bran Flakes (closed but undated), a 16-ounce bag of Lays Classic chips, a 25 pound bag of allˆpurpose flour, and three unlabeled, undated bags containing a brownˆcolored substance. Dietary Manager #524 reported, I am not sure what that could be.Observation on 03/17/26 at 10:00 A.M. with Dietary Manager #524 revealed a grease residue line along the side of the grill. The walk-in freezer floor was observed to have spilled sherbet on the floor, and Dietary Manager #524 verified the walk-in cooler had peeling paint on the floor under the stored milk.Observation on 03/17/26 10:20 A.M., Dietary Manager #524 verified grease residue along the side of the grill, dirty surfaces, and spilled sherbet on the freezer floor that had not been cleaned. Peeling paint was observed on the walkˆin cooler floor beneath stored milk. During an interview, Dietary Aid #638 stated he did not remember seeing the posted cleaning schedule. Additional observations with Dietary Manager #524 revealed improper food storage above the prep area, including an open, unsealed box of corn starch; undated containers of Italian seasoning (32 ounce), cilantro leaves (0.5 ounce), black pepper (16 ounce), cinnamon (16 ounce), and ground mustard (16 ounce), as well as grime on the bottles and multiple crumbs on the prep shelf.On 03/23/26 at 9:40 A.M., a dented sixˆpound can of sliced apples was observed on the shelf for active use. Dietary Aid #638 verified the dented can had been kept for use and stated that dented cans were supposed to be placed by the outgoing kitchen door for pickup and disposal by the food service delivery truck.Additional observation on 03/23/26 at 10:00 A.M. revealed a dark residue on the plastic lip inside the ice machine, which transferred to a paper towel when wiped. Dietary Aid #638 stated he was unsure whether a tracking sheet existed for emptying and cleaning the ice machine.Review of the undated facility's document titled Daily Tasks and Cleaning Checklist for Dietary Aides indicated that each shift was required to clean and sanitize all counter areas, move the steam table and scrub underneath, and sweep and mop the walkˆin. Review of the Daily Cooks Checklist (undated) showed requirements to clean and sanitize all surfaces and prep tables, wipe down the steam table and its cracks, ensure all food items in coolers were labeled, sealed, wrapped, and dated, and clean the stove top, backsplash, steamer top, grill, floor, and spice rack.Review of the facility policy titled Sanitization, revised October 2008, stated that food service areas must be maintained in a clean and sanitary manner, counters and shelves must be kept clean and in good repair, and non-foodˆcontact surfaces must be cleaned regularly and frequently enough to prevent buildup of grime.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review, the facility failed to ensure a comfortable, homelike environment when maintenance failed to maintain water temperatures in resident rooms. This affected six (Residents #24, #37, #26, #14, #46, and #42) residents reviewed for homelike environment and had the potential to affect all residents in the facility. The facility census was 43.Findings include:On 03/16/26 at 8:42 A.M., an interview with Resident #24 revealed the water in her sink did not get warm unless it ran for a really long time. Observation at the time of the interview revealed the water in the sink was cold, even after running for over two minutes. The resident stated, I shower in the shower room, so it really only is a problem to wash my face. She indicated the certified nurse aides (CNAs) mainly used the water to clean up her roommate (Resident #37), so she just dealt with it.On 03/16/26 at 8:44 A.M., an observation of water temperature in Resident #26's room revealed the water was cold at the sink. After running the water for five minutes, the water still was cold to the touch. This was confirmed by CNA #518 on 03/16/26 at 8:45 A.M.On 03/16/26 at 8:50 A.M., an observation of water temperature in Resident #14's room revealed the water was cold at the sink. After running the water for approximately five minutes, the water remained cold to the touch. This was confirmed by CNA #518 on 03/16/26 at the time of the observation.On 03/16/26 at 9:03 A.M., an observation of water temperature in Resident #46's room and interview with Resident #46 revealed the water was cold in the sink. The shelf beside the sink was noted to have dirty adaptive equipment, and the resident stated, the water in that bathroom sink does not get hot. If it ever does, I would wash that silverware.On 03/16/26 at 9:20 A.M., an interview with Maintenance Supervisor (MS) #555 revealed he noticed a circulation tank for the water system was bad on 03/13/26. He called a plumber who was to be at the facility on 03/16/26. He felt with the residents being old, they would shower in the shower room, so only the CNAs would use the sink, so he did not see the temperature of the water as a problem.On 03/16/26 at 9:30 A.M., an observation with MS #555 revealed a low water temperature in Resident #42's room. After running the water for a timed five minutes, the water temperature at the sink reached 99.2 degrees Fahrenheit (F). Observation of the water temperature at the sink of room [ROOM NUMBER], which was unoccupied, revealed a temperature of 98.7 degrees F after three minutes of running. These temperatures were confirmed by MS #555 at the time of observation.On 03/17/26 at 11:07 A.M., an interview with MS #555 revealed he completed water temperatures in rooms weekly. He did not mark which rooms he was testing. If the temperature was too high or too low, which he believed was 90 degrees F to 120 degrees F, he would adjust the water temperature up or down. If it was still an issue, he would bleed off the line, which could have been clogged. He would then re-check the temperatures, but he did not document these temperatures or any of the follow up maintenance.Review of facility logbook of hot water temperatures, dated 01/15/26, revealed an E Hall temperature of 103 degrees F. This was confirmed by MS #555 on 03/17/26 at 11:07 A.M.Review of facility logbook of hot water temperatures, dated 03/13/26, revealed an E Hall temperature of 104 degrees F. This was confirmed by MS #555 on 03/17/26 at 11:07 A.M.Review of a facility policy titled Homelike environment, dated February 2021, revealed the facility residents were provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The facility staff and management would maximize the characteristics of the facility to reflect a personalized, homelike setting, which included comfortable and safe temperatures. Review of an undated facility policy titled Water Temperatures revealed the water in the facility should be kept within a temperature range to prevent scalding. Water temperatures in resident rooms, bathrooms, common areas and tub/shower areas should be between the temperatures of 105-120 degrees F. Maintenance staff was to be responsible for checking thermostats and temperature controls of and record these in a maintenance log. Any time (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the water temperature felt excessive to the touch, staff would report the finding to the immediate supervisor.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure assessments were accurately completed for Residents #7 and #12. This affected two residents (#7 and #12) of 16 residents reviewed for Minimum Data Set (MDS) 3.0 assessments. The facility census was 43.Findings include: 1. Review of the medical record for Resident #7 revealed an admission date of 04/15/25 with diagnoses including depression, dementia and anxiety. Review of the physician's orders for Resident #7 revealed she had an order for Risperdal 0.25 milligrams (mg) at bedtime for paranoia and agitation dated 07/16/25. Risperdal was classified as an antipsychotic medication. Review of the 02/19/26 modified annual MDS 3.0 assessment for Resident #7 revealed on section N415 under high-risk drugs classes she was taking an antipsychotic. However, under section N450 antipsychotic medication review, the facility answered that antipsychotics were not received since admission or the prior assessment. Interview on 03/23/26 at 9:43 A.M. with Registered Nurse (RN) #535 verified Resident #7's MDS dated [DATE] section N was incorrectly entered for question N450 for her receiving antipsychotics as Resident #7 was on Risperdal. 2. Review of the medical record for Resident #12 revealed an admission date of 01/22/26. Diagnoses included metabolic encephalopathy, urinary tract infection, pneumonia, insomnia, generalized anxiety disorder, disorder of thyroid, chronic pain, chronic respiratory failure unspecified, neuromuscular dysfunction of the bladder, acquired absence of other organs, chronic obstructive pulmonary disease, essential hypertension, tracheostomy, dependence on a respirator, hyperlipidemia, type two diabetes mellitus, rheumatoid arthritis, fracture of left femur, history of transient ischemic attack and cerebral infarction without residual deficits, unspecified osteoarthritis, unspecified fracture of the shaft of the humerus, left arm, other specified disorders of bone density, personal history of other diseases of the nervous system and sense organs, and unspecified convulsions. Review of a quarterly MDS version 3.0 assessment, dated 02/23/26, revealed a Brief Interview for Mental Status (BIMS) score of 13 on a 0-15 scale. A score of 13 indicated Resident #12 had intact cognitive function or normal thinking and memory. The resident had impairment on one side for both upper and lower extremities. She was dependent on staff for toileting hygiene, showering and/or bathing, lower body dressing and putting on footwear. She required supervision to perform personal hygiene and dress her upper body. The resident had an indwelling Foley catheter and was always incontinent of bowel. Resident #12 revealed a determination of pressure ulcer risk. For question M0100, the facility answered no to the question did the resident have a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device. For question M0210, the facility marked yes to the question does the resident have one or more unhealed pressure ulcers/injuries? On M0300, the facility indicated the resident had one Stage II pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough, may also present as an intact or open/ruptured serum filled blister) which was present on admission. This was confirmed by RN #603 on 03/18/26 at 10:00 A.M.For question N0300, the facility recorded the resident had one injection during the past seven days (prior to the completion of the MDS). For question N0350, the facility recorded the resident received insulin injections on one day during the seven days prior to the completion of the MDS. This was confirmed by RN #603 on 03/18/26 at 10:00 A.M. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record for Resident #12 revealed on 02/19/26 the resident had a blood glucose of 166 which required insulin coverage by subcutaneous injection of 2 units of Humalog Kwikpen 100 units per milliliter (u/ml) . The record also revealed on 02/20/26, the resident had a blood glucose of 185 which required insulin coverage by subcutaneous injection of 2 units of Humalog Kwikpen 100 u/ml. This was confirmed by RN #603 on 03/18/26 at 10:00 A.M. An interview with RN #603 on 03/18/26 at 10:00 A.M. revealed Resident #12 had two Stage II pressure ulcers on 02/23/26 when the MDS was completed. The pressure ulcer on the resident's coccyx was resolved on 02/25/26, and the pressure ulcer on her buttocks was resolved on 02/26/26. RN #603 also reported that the resident received subcutaneous insulin injections according to a sliding scale. In the seven days prior to 02/23/26, Resident #3 received insulin coverage on both 02/19/26 and 02/20/26. On 03/23/26 at 9:43 A.M., an interview with RN #535 revealed she had been an MDS coordinator for two years and was responsible for the entire building. She confirmed the MDS section M question M0100 for Resident #12 was incorrect. The correct answer should have been yes.

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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 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. Based on observation, record review, review of facility policy and interview, the facility failed to ensure oxygen was provided to Resident #3 as ordered by the physician and/or failed to ensure orders were updated to reflect the current plan for treatment. This affected one resident (#3) of two residents reviewed for respiratory care. The facility census was 45. Findings include:Review of the medical record for Resident #3 revealed an admission date of 11/18/25 with diagnoses including chronic atrial fibrillation, depression, diffuse traumatic brain injury with loss of consciousness of unspecified duration, dysphagia, heart failure and muscle weakness.Review of physician orders for Resident #3 revealed an order dated 11/18/25 to obtain the resident's vital signs monthly. Review of a care plan for Resident #3, (revised 12/01/25), revealed a focus of care for impaired respiratory status related to the resident being oxygen dependent. The goal was for the resident to be free from signs and symptoms of hypoxia. Interventions (dated 11/19/25) included oxygen as ordered or as needed (PRN), monitoring lung sounds for wheezing or crackles PRN, monitoring vital signs and pulse oximetry PRN. Review of physician orders for Resident #3 revealed an order dated 12/02/25 for oxygen. The order read for continuous oxygen one (1) liter per minute (LPM) received via nasal cannula. Review of a Minimum Data Set (MDS) assessment, dated 01/28/26, revealed Resident #3 had a Brief Interview of Mental Status (BIMS) score of 12 on a 0-15 scale. A BIMS score of 12 would indicated moderate impairment with thinking and memory. Review of the special treatment section of the MDS revealed the resident was on oxygen but did not include the frequency of the oxygen therapy. Review of the medical record for Resident #3 revealed pulse oximeter readings at a minimum of daily from 12/18/25 through 01/20/26, and then a reading on 02/18/26 and 03/18/26. Readings completed on 01/15/26 indicated the resident was receiving oxygen by ventilator. A reading on 01/26/26 indicated the resident was receiving oxygen by trach. However, the resident did not have a tracheostomy, nor was he on a ventilator. This was verified by the Director of Nursing (DON) during an interview on 03/18/26 at 1:56 P.M.On 03/16/26 at 9:59 A.M., Resident #3 was observed in his room without oxygen in place. An interview with Resident #3 at the time of the observation revealed he had difficulty holding a conversation but could answer yes or no questions appropriately. There was an oxygen concentrator observed in the resident's room with dated tubing, which was not being used, and the resident could not access. The resident indicated he did not know if he was supposed to be on oxygen or not.On 03/17/26 at 12:00 P.M., an observation of Resident #3 revealed he was not wearing any form of oxygen. His room contained an oxygen concentrator, which was not on, with the cannula wrapped up and on the opposite side of the room. The resident said hello; however, he did not interact beyond that.On 03/17/26 at 1:40 P.M., an observation of Resident #3 revealed he was sleeping with sonorous respirations. He was not wearing oxygen. The oxygen concentrator was not on, was on the opposite side of the room and could not be accessed by the resident.On 03/18/26 at 8:05 A.M., an observation of Resident #3 revealed he was not on oxygen. The oxygen concentrator was not on and was on the opposite side of the room. The resident appeared pale, his lips were cyanotic, his bilateral arms showed signs of mottling (purple, marble-like discoloration). The resident appeared minimally responsive when his name was called by this surveyor.Review of the medical record for Resident #3 revealed a treatment administration record (TAR) for the month of March 2026. The record reflected the nurses were documenting Resident #3 was wearing continuous oxygen one LPM via nasal cannula twice daily per the record. This was verified during an interview with the DON on 03/18/26 at 1:56 P.M.On 03/18/26 at 8:38 A.M., an interview with Registered Nurse (RN) #630 revealed the nurses check each resident's oxygen level (SpO2) daily. She stated she had checked Resident #3 in the morning, and he had a SpO2 of 92%. During the interview, the RN revealed she could not recall the last time the resident had oxygen by nasal cannula. She thought it had been quite some time.On 03/18/26 at 8:42 A.M., an observation of Resident #3 revealed a pulse oximeter reading of 98% with the resident wearing two liters of oxygen. Resident #3 was able to answer surveyor question (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regarding breakfast and about shaving at this time. On 03/18/26 at 12:36 P.M., an interview with Physician (MD) #652 revealed (Resident #3) has progressed with his demise. He had been basically end of life care since the first week of January (the facility providing end of life care although the resident did not receive Hospice services). During the interview, the MD denied Resident #3 had an order for oxygen. However, the surveyor verified the current order and noted MD #652 had signed the physician order for oxygen administration. The MD indicated she thought the oxygen was ordered as needed. She stated they had a discussion in January (2026), and the resident's family thought he needed oxygen due to his traumatic brain injury (TBI). On 03/18/26 at 1:56 P.M., an interview with the DON confirmed nurses had documented Resident #3 was receiving oxygen at one LPM via nasal cannula twice daily from 03/01/26 until the morning of 03/18/26. The DON further confirmed the resident had not actually been provided the oxygen (as physician ordered) during this time. The DON confirmed the most recent care plan for Resident #3 indicated the resident was oxygen dependent and was to have vital signs and pulse oximeter monitored PRN. His oxygen was to be delivered continuously via nasal cannula, and he did not have a trach and was not on a ventilator.On 03/18/26 at 2:26 P.M., an interview with the Resident Representative (RR) for Resident #3 revealed the staff had reported to family they were not going to leave the resident's oxygen on because it was causing him agitation (this was not documented in the resident's medical record). The representative revealed she was under the impression that as soon as the resident was no longer agitated, the oxygen would be continuous again. She believed it had been at least two weeks since the agitation had subsided and indicated she believed the resident did require oxygen. Review of a facility policy titled Oxygen Administration, dated October 2021, revealed guidelines for safe oxygen administration. The policy indicated there was to be a physician order for oxygen, the care plan should address any special oxygen needs for the resident, and the oxygen should be administered by the route (nasal cannula, oxygen mask, etc.) ordered. Documentation should include time, date, who administered, rate of oxygen flow, all assessment data obtained before, during and after oxygen was applied, and how the resident tolerated the procedure. If a resident refused the procedure, the supervisor should be notified, and any other information should be reported in accordance with the facility policy and professional standards of practice.Review of an undated facility policy titled Oxygen Therapy Monitoring revealed nursing staff would monitor the need for oxygen therapy by checking oxygen saturation levels with a handheld pulse oximeter machine to maintain a saturation level above 92% or a level specified by the physician. The policy indicated if a resident showed signs of hypoxia (shortness of breath, tachycardia or rapid heart rate, cyanosis, agitation or confusion), an oxygen saturation level should be checked. If below 92%, oxygen should be applied starting at two liters per minute and re-checked after two minutes to be sure the level was rising. The policy further indicated after resident's saturation level was stabilized above 92%, the physician should be informed of the resident's condition along with oxygen saturation level before and after oxygen was applied. Oxygen orders could be written as follows: Oxygen at 2LPM via nasal cannula to maintain SpO2 above 92%, check pulse ox every shift and PRN, or titrate oxygen PRN to maintain a SpO2 greater than 92%, if saturation levels are above 95% titrate oxygen to room air.

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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. Based on record review, interview and facility policy review, the facility maintain a medical record in accordance with accepted professional standards and practices, resulting in inaccurate documentation for Resident #3. This affected one resident (#3) of 16 residents whose records were reviewed for accuracy. The facility census was 43.Findings include:Review of the medical record for Resident #3 revealed an admission date of 11/18/25. Diagnoses included alcohol abuse, anemia, dementia, mild without behavioral disturbance, difficulty in walking, disorder of prostate, essential hypertension, history of falling, insomnia, neuromuscular dysfunction of the bladder, pressure ulcer of right buttock Stage IV pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle) of the sacral region, alcoholic polyneuropathy, chronic atrial fibrillation, depression, diffuse traumatic brain injury with loss of consciousness of unspecified duration, dysphagia, heart failure, unspecified, hyperlipidemia, muscle weakness, osteomyelitis of vertebra, sacral and sacrococcygeal region, other fracture of base of skull, and unspecified convulsions.Review of a care plan for Resident #3, last updated 12/01/25, revealed a focus of care for impaired respiratory status related to the resident being oxygen dependent. The goal was for the resident to be free from signs and symptoms of hypoxia. Interventions included oxygen as ordered or as needed, monitoring lung sounds for wheezing or crackles as needed, monitoring vital signs and pulse oximetry as needed, with all interventions updated last on 11/19/25.Review of physician orders for Resident #3 revealed an order dated 12/02/25 for oxygen. The order read: Continuous oxygen 1 liter per minute (LPM) received via nasal cannula. Review of the Treatment Administration Record (TAR) for Resident #3 revealed nursing staff had marked the administration as completed for his order of continuous oxygen 1 LPM via nasal twice daily from 03/01/26 to 03/17/26. The Director of Nursing (DON) verified on 03/18/26 at 1:56 P.M. that nursing staff had documented they were administering oxygen at 1 LPM despite not being utilized.Review of a Minimum Data Set (MDS) version 3.0 assessment, dated 01/28/26, revealed Resident #3 had a Brief Interview of Mental Status (BIMS) score of 12 on a 0-15 scale. A BIMS score of 12 indicated moderate problems with thinking and memory. Review of the special treatment section of the MDS revealed the resident was on oxygen but did not reveal the frequency of the oxygen therapy. Review of the medical record for Resident #3 revealed pulse oximeter readings at a minimum of daily from 12/18/25 through 01/20/26, and then a reading on 02/18/26 and 03/18/26. Readings completed on 01/15/26 indicated the resident was receiving oxygen by ventilator. A reading on 01/26/26 indicated the resident was receiving oxygen by trach. The resident did not have a tracheostomy, nor was he on a ventilator. This was verified by the DON on 03/18/26 at 1:56 P.M.On 03/18/26 at 8:38 A.M., an interview with Registered Nurse (RN) #630 revealed the nurses check each resident's pulse ox (SpO2) daily. She checked Resident #3's SpO2 in the morning, and he had a SpO2 of 92% at 6:42 A.M. She could not recall the last time the resident had oxygen by nasal cannula. She thought it had been quite some time.On 03/18/26 at 1:56 P.M., an interview with the DON confirmed nurses had documented Resident #3 was receiving oxygen 1 LPM via nasal cannula twice daily from 03/01/26 until the morning of 03/18/26. She further confirmed he had not been wearing the oxygen all of those dates. She confirmed the most recent care plan for Resident #3 indicated the resident was oxygen dependent and was to have vital signs and pulse oximeter monitored as needed. His oxygen was to be delivered continuously via nasal cannula, and he did not have a trach and was not on a ventilator.Review of a facility policy titled Charting and Documentation, revised 07/17, revealed all services provided to a resident toward the care plan goals or any changes in the resident's medical, physical, functional or psychosocial condition would be documented in the medical record. The documentation should be objective, complete, and accurate.