STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375527	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garland Road Nursing & Rehab Center	1404 North Garland Road Enid, OK 73703

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 41318 Based on observation, record review, and interview, the facility failed to assess a resident for self administration of medication and obtain a physician order for a resident to self administer medication for 1 (#55) of 1 sampled resident reviewed for self administration of medication. The administrator identified 91 residents resided in the facility. Findings: On 04/28/25 at 2:10 p.m., LPN #1 was observed to go into Resident #55's room, pick up a tube of mupirocin (topical antibiotic) ointment from the resident's bedside table, and apply it to Resident #55's head. On 05/06/25 at 12:55 p.m., Resident #55 was observed sitting in their recliner in their room. A medication box of triple antibiotic ointment was observed on the dresser next to the resident. May keep at bedside was hand written on the box. A policy titled Bedside Medication Storage, dated 01/2024, read in part, Bedside medication storage is permitted for residents who are able to self-administer medications, upon the written order of the prescriber and when it is deemed appropriate in the judgment of the nursing care center's interdisciplinary resident assessment team. A Quarterly Assessment, dated 03/13/25, showed Resident #55's BIMS score was 15, which indicated the resident's cognition was intact. There was no assessment or physician's orders located in Resident #55's clinical record. On 05/06/25 at 12:56 p.m., Resident #55 stated the nurse applied the ointment to the back of their head because it was difficult for them to apply it. On 05/06/25 at 1:07 p.m., LPN #1 stated they had hand written may keep at bedside on the triple antibiotic ointment box. LPN #1 stated a physician's order was required for residents to keep medication at bedside. On 05/06/25 at 1:11 p.m., LPN #1 stated they could not locate an order for medication to be kept at bedside for Resident #55. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/06/25 at 2:26 p.m., the DON was asked what was the policy for residents to keep medication at their bedside. They stated the resident had to have an assessment and a physician's order. On 05/06/25 at 2:27 p.m., the DON was asked if Resident #55 had an assessment or a physician's order to be able to keep medication at their bedside. They stated, No.

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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** 46702 Based on obsevation, record review, and interview, the facility failed to ensure a resident's room was free from odors for 1 (room [ROOM NUMBER]) of 24 rooms observed for odors. The administrator identified 91 residents resided in the facility. Findings: On 04/30/25 at 9:59 a.m., room # 217 was observed to have a strong odor of urine. A policy titled Resident Room Cleaning, dated 11/2021, read in part, To provide a clean, attractive, and safe environment for residents, visitors, and staff. On 04/30/25 at 10:04 a.m., CNA #5 was asked what they smelled in room [ROOM NUMBER]. They stated they smelled urine. CNA #5 stated the urine smell came from the floor and the bathroom because the resident was incontinent. They were asked if the smell facilitated a homelike environment. CNA #5 stated, No, it's not a homelike environment. On 04/30/25 at 10:20 a.m., LPN #2 was asked what the facility's policy and rule was about having a homelike environment. They stated the facility should be kept clean with no odors and made to feel as homelike as possible. LPN #2 was asked what they smelled in room [ROOM NUMBER]. They stated, I smelled urine in the room. They were asked what they thought about the smell. LPN #2 stated, We need to get that smell out of there. I don't think it's home like. I think it's the floor. On 04/30/25 at 10:46 a.m., the DON was asked what they observed in room [ROOM NUMBER]. They stated the room smelled like urine. They were asked if the urine smell facilitated a home like environment. The DON stated it was not their standard and the room should not smell.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702 Based on observation, record review and interview, the facility failed to ensure MDS assessments were accurate for 2 (#28 and #81) of 24 residents sampled for MDS assessments. The administrator identified 91 residents resided in the facility. Findings: A policy titled Resident Assessment, dated 09/13/17, read in part, It is the standard of Care to conduct, initially and periodically, a comprehensive, accurate assessment of each resident's functional capacity utilizing the Minimum Data set (MDS) according to the guidelines set forth in the Resident Assessment Instrument (RAI) manual.The assessment process included direct observation, the medical record, as well as communication with the resident and direct care staff across all shifts. 1. Resident #28's admission record, dated 09/14/24, showed they were admitted with diagnoses which included end stage renal disease and displaced fracture of the lower right leg. Resident #28's physician orders, dated 09/14/24, read in part, Dialysis Monday, Wednesday and Friday on 1 time per day Monitor shunt/graft/fistula. Resident #28's admission assessment, dated 9/17/24, did not show in section O the resident received dialysis services. Resident #28's quarterly assessment, dated 12/18/24, did not show in section O the resident received dialysis services. Resident #28's quarterly assessment, dated 3/20/25, showed their cognition was intact with a BIMS score of 15. The assessment did not show the resident received dialysis in section O. On 04/29/25 at 9:22 a.m., Resident #28 was asked about their dialysis services. They stated they went to dialysis on Monday, Wednesday, and Friday since admission. On 05/01/25 at 10:41 a.m., the DON was asked about Resident #28's dialysis services. They stated the resident went to dialysis and had orders since 09/14/24 when they were admitted . On 05/01/25 at 10:45 a.m., MDS coordinator #1 was asked how they ensured MDS assessments were accurate and reflected the current status of the resident. They stated they interviewed residents, staff, and reviewed documentation in look back period. They were asked what did section O show in Resident #28's 09/17/24, 12/18/24, and 03/20/25 assessments. MDS Coordinator #1 stated it showed none of the above for special treatments in section O. They were asked if the resident received dialysis during the look back period for each of the assessments. MDS Coordinator #1 stated, Yes, that's an error on my part. They stated they missed the dialysis on the admission assessment and did not go through and check on the next assessments to ensure dialysis was selected in special treatments section O of the assessments. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 05/05/25 at 2:02 p.m., Resident #81 was observed with no natural teeth and was edentulous (no natural teeth or tooth fragments). Resident #81's admission record, dated 01/28/25, showed the resident was admitted with diagnoses which included alcoholic cirrhosis of the liver, chronic hepatic failure, and liver cell carcinoma. Resident #81's admission assessment, dated 01/31/25, showed moderate cognitive impairment with a BIMS score of 12, required set up or clean up assist for oral hygiene, and section L showed the resident was not edentulous. On 04/28/25 at 2:27 p.m., Resident #81 stated they needed dentures and had no natural teeth. They stated they were never offered dental services, they ate a regular diet, and they had trouble eating some things that were hard. Resident #81 stated they had pain and discomfort in their mouth and would like to get dentures. On 05/05/25 at 2:04 p.m., LPN #3 was asked about Resident #81's oral care needs. They stated the resident was admitted with no teeth. On 05/05/25 at 2:10 p.m., the DON was asked about Resident #81's teeth. They stated the resident was edentulous. The DON was asked to review Resident #81's admission assessment, dated 01/28/25, section L. They stated the assessment showed the resident had all their natural teeth and was not edentulous. They stated the assessment was not correct. On 05/05/25 at 2:19 p.m., MDS coordinator #1 was asked what the RAI manual said on how section L should be assessed. They stated, I can not tell you what I did at that time. They were asked what did section L show on Resident #81's admission assessment dated [DATE]. MDS Coordinator #1 stated the assessment did not show the resident was edentulous. They stated they relied upon chart reviews before interviews for a lot of information and did not do a visual assessment of Resident #81's teeth.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 41318 Based on observation, record review, and interview, the facility failed to ensure: a. a physician's order was obtained for a medication kept at beside to treat an abrasion for 1 (#55); b. a physician's order was in place for a treatment that was provided for 1 (#55); c. an abrasion was assessed routinely for 1 (#55) of 2 sampled residents reviewed for skin conditions; and d. communication was maintained with hospice for 1 (#68) of 1 sampled resident reviewed for hospice services. The administrator identified 91 residents resided in the facility. The ADON identified 10 residents received hospice services. Findings: 1. On 04/28/25 at 2:10 p.m., LPN #1 was observed to go into Resident #55's room, pick up a tube of mupirocin (topical antibiotic) ointment from the resident's bedside table, and apply it to Resident #55's head. On 05/06/25 at 12:55 p.m., the back of Resident #55's head was observed. A ribbon of cotton was observed on the left side of Resident #55's head. A medication box of triple antibiotic ointment was observed on the dresser next to the resident. The directions on the box showed to Apply to forehead twice a day. The box was dated 12/19/24. A policy titled Skin Data Collection, dated July 2018, read in part, A licensed nurse will collect data during weekly skin evaluations. A policy titled Non-Pressure Wounds: Abrasions, dated July 2018, read in part, To provide care for abrasions consistent with professional practice standards. A Quarterly Assessment, dated 03/13/25, showed Resident #55's BIMS score was 15, which indicated the resident's cognition was intact. An Incident Care Report, dated 04/12/25, showed Resident #55 sustained an abrasion to their head. There were no assessments or physician's orders located in Resident #55's clinical record regarding the abrasion on the back of Resident #55's head. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/06/25 at 12:56 p.m., Resident #55 stated the beauty operator washed their hair today, cleaned the abrasion on their head, and placed cotton on it. They stated staff applied ointment to the abrasion because it was difficult for them to do. On 05/06/25 at 12:58 p.m., the beauty operator stated they had washed Resident #55's hair. They stated they put a ribbon of cotton on the area on the back of Resident #55's head because it was bleeding. They stated the abrasion opened every time they washed Resident #55's hair. On 05/06/25 at 1:01 p.m., LPN #1 stated Resident #55 had fallen and obtained a wound on the back of their head. On 05/06/25 at 1:07 p.m., LPN #1 stated the directions on the medication box showed to Apply to forehead twice a day. LPN #1 stated the box was dated 12/19/24. LPN #1 was asked when Resident #55 had fallen. They stated, About a month ago. LPN #1 was asked if the ointment was used to treat the abrasion on the back of Resident #55's head. They stated, Yes. On 05/06/25 at 1:11 p.m., LPN #1 stated they could not locate a physician's order for the medication for Resident #55. On 05/06/25 at 1:17 p.m., the DON stated if the resident had an abrasion, there would be an active order and weekly assessments. The DON stated they were not able to locate an active order or assessments for Resident #55. The DON stated they were not able to locate an order for mupirocin. 46702 2. On 04/30/25 at 10:06 a.m., an oxygen concentrator and two oxygen tanks were observed in Resident #68's room. On 04/30/25 at 10:20 a.m., an oxygen concentrator and two oxygen tanks were observed in Resident #68's room. Resident #68's admission record, dated 10/30/24, showed they were admitted with diagnoses which included cirrhosis of the liver and nonalcoholic steatohepatitis. Resident #68's hospice medication report, dated 12/02/24, read in part, Oxygen Gas for Inhalation .Reason: Dyspnea/O2 .Administer 2 L oxygen as needed for respiratory comfort. Resident #68's quarterly assessment, dated 03/11/25, showed their cognition was intact with a BIMS score of 15. Resident #68's physician orders, dated 04/30/25, showed the resident had an order for hospice services with a start date on 12/02/24. The physician orders did not document Resident #68 had an order for oxygen. On 04/29/25 at 9:01 a.m., Resident #68 was asked about their hospice services. They stated they were on hospice and was not sure who to contact to discuss their care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/30/25 at 10:20 a.m., LPN #2 was asked if Resident #68 had orders for oxygen. They stated the resident did not have orders for oxygen in the resident's physician orders. They checked the hospice orders in a book and stated they had some problems with hospice communicating physician orders. They stated the resident had hospice orders for oxygen dated 12/02/24. They stated somebody just missed adding the hospice orders to the physician orders. On 04/30/25 at 10:46 a.m., the DON was asked if Resident #68 had orders for oxygen. They stated there were no physician orders for oxygen. The DON reviewed the hospice orders, dated 12/02/24, and stated the resident had an order for oxygen since 12/02/24. The DON was asked why there was no oxygen orders in the resident's physician orders. The DON stated it was a lack of communication problem with hospice.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 46702 Based on observation, record review, and interview, the facility failed to ensure oxygen tanks were stored in a safe place for 1 (#68) of 2 residents sampled for safe oxygen tank storage. The ADON identified 17 residents received oxygen therapy. Findings: On 04/30/25 at 10:06 a.m., an oxygen concentrator and two oxygen tanks were observed in Resident #68's room. One oxygen tank was secured to a cart with a strap. One tank was observed in the corner of the room loose and leaned up against the wall. On 04/30/25 at 10:20 a.m., oxygen tanks were observed in Resident #68's room. One oxygen tank was secured to a cart with a strap. One tank was observed in the corner of the room loose and leaned up against the wall. An undated policy titled Oxygen Storage Handling, read in part, All oxygen cylinders are to be stored in a fire safety closet and locked .Cylinders shall be stored away from doors and secured to its location by a non combustible strap or chain to avoid tipping. Resident #68's admission record, dated 10/30/24, showed they were admitted with diagnoses which included cirrhosis of the liver and nonalcoholic steatohepatitis. Resident #68's hospice medication report, dated 12/02/24, read in part, Oxygen Gas for Inhalation .Reason: Dyspnea/O2 .Administer 2 L oxygen as needed for respiratory comfort. Resident #68's quarterly assessment, dated 03/11/25, showed their cognition was intact with a BIMS score of 15. On 04/30/25 at 10:20 a.m., LPN #2 stated two oxygen tanks were stored in Resident #68's room. LPN #2 was asked what the policy was for storing oxygen. They stated oxygen tanks should be stored in the designated oxygen room. On 04/30/25 at 10:39 a.m., the DON asked what their policy was for storing oxygen tanks. The DON stated it had to be secured and stored in the oxygen room.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 46702 Based on observation, record review, and interview, the facility failed to ensure dental services were provided for 1 (#81) of 24 residents sampled for dental services. The ADON identified 73 resident had a payer source of Medicaid and eight residents received dental services. Findings: An undated policy titled 'Availability of Services, read in part, Oral healthcare and dental services will be provided to each resident.Social Services will be responsible for making necessary dental appointments. An undated policy titled Routine Dental Care, read in part, Our facility's routine dental care includes, but is not limited to: .Consultation with the resident, staff, and the dental consultant. Resident #81's admission record, dated 01/28/25, showed the resident was admitted with diagnoses which included alcoholic cirrhosis of the liver, chronic hepatic failure, and liver cell carcinoma. The record showed they had a payer source of Medicaid. Resident #81's admission assessment, dated 01/31/25, showed moderate cognitive impairment with a BIMS score of 12, required set up or clean up assist for oral hygiene, and section L showed the resident was not edentulous (no natural teeth or tooth fragments). On 04/28/25 at 2:27 p.m., Resident #81 was asked about any concerns. The resident stated they needed dentures and had no natural teeth. They stated they were never offered dental services, they ate a regular diet, and they had trouble eating some things that were hard. Resident #81 stated they had pain and discomfort in their mouth and would like to get dentures. On 05/05/25 at 2:04 p.m., LPN #3 was asked about Resident #81's oral care needs. They stated the resident was admitted with no teeth. On 05/05/25 at 2:10 p.m., the DON was asked about Resident #81's teeth. They stated the resident was edentulous since admission. On 05/05/25 at 2:37 p.m., the social services director was asked to discuss Resident #81's dental needs. They stated the resident had not received dental services since admission and transitioned from skilled care to long term care on 02/09/25. They stated the resident had a payer source of Medicaid and they missed offering to set the resident up for dental care and services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 35749 Based on observation, record review, and interview, the facility failed to ensure: a. staff donned gloves when applying an ointment to a resident for 1 (#55) of 2 sampled residents reviewed for wound care; b. staff changed gloves while performing peri-care to a resident for 1 (#23) of 1 sampled resident observed for peri-care; c. trends in infections were identified through monthly review of tracking for 3 of 3 sampled months reviewed; and d. respiratory equipment was bagged and labeled for 1 (#24) of 2 sampled residents reviewed for respiratory care. The administrator identified 91 residents resided in the facility. The ADON identified 17 residents received oxygen services and 28 residents had nebulizers. Findings: 1. On 04/28/25 at 2:06 p.m., LPN #1 was observed to apply mupirocin (topical antibiotic) ointment to the back of Resident #55's head with out wearing gloves. A policy titled Non-Pressure Wound, dated July 2018, showed to follow standard precautions and infection control methods. A Quarterly Assessment, dated 03/13/25, showed Resident #55's BIMS score was 15, which indicated the resident's cognition was intact. On 04/28/25 at 3:15 p.m., LPN #1 stated the floor nurses provided wound care when the wound care nurse was not available. LPN #1 stated they would perform handwashing and gather their supplies prior to completing wound care. LPN #1 was asked about wearing gloves when applying an ointment. They stated they did not because they used a lot of soap and water. They stated they did not like using alcohol gel on their hands. On 04/29/25 at 10:18 a.m., the IP stated staff were to wash their hands and wear gloves when they were performing wound care on a resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 04/28/25 at 2:25 p.m., Resident #23 was observed laying in bed. CNA #1 and CNA #2 were observed to provide incontinent care to Resident #23. Resident #23 was observed to have had a bowel movement. CNA #2 was observed to wipe Resident #23 and then place clean linen under the resident. CNA #2 was not observed to have changed their gloves after wiping the resident and prior to touching clean linen. CNA #1 was observed to take the soiled linen off Resident #23's bed and place them on the floor. CNA #1 was observed to wipe Resident #23 multiple times and bowel was observed on the wipes. CNA #1 and CNA #2 was observed to assist the resident up in bed. CNA #1 was observed to adjust the resident's gown. CNA #1 was not observed to change their gloves. CNA #1 picked up the soiled linen and placed it back on the floor closer to the resident's door. On 04/28/25 at 2:38 p.m., CNA #1 removed the gloves, but was not observed to provide hand hygiene. CNA #1 was observed to enter another resident's room and adjust the air temperature. CNA #1 was observed to push their hair behind their ears. On 04/28/25 at 2:50 p.m., CNA #1 was observed standing in hall way with their hand on the hand rail. CNA #1 was observed to go to shower room door, push in the code to unlock the door, and go inside. CNA #1 was observed to begin washing another resident's hair. CNA #1 had not been observed to have performed hand hygiene after assisting with peri-care, removing gloves, going into another resident's room, or prior to assisting a resident with their shower. A policy titled Perineal Care, dated 04/28/24, showed to apply clean gloves, provide assistance to a resident, dispose of gloves and perform hand hygiene. The policy showed to apply new gloves before placing a new brief or changing the linen. A policy titled Hand Hygiene, dated February 2025, showed hand hygiene was to be completed before resident contact, after contact with soiled/contaminated items, toileting or assisting other with toileting, or removing gloves. A Quarterly Assessment, dated 03/06/25, showed Resident #23's BIMS score was 5, which indicated the resident's cognition was severely impaired. The assessment showed Resident #23 was dependent on staff for toilet hygiene and was always incontinent of bowel and bladder. On 04/28/25 at 2:59 p.m., CNA #2 stated staff were to use hand sanitizer between glove changes. CNA #2 stated they had been instructed to put soiled linens on the floor. CNA #2 stated staff should change soiled gloves before touching clean linen. CNA #2 did not recall changing their gloves after cleaning bowel off of the resident. On 04/29/25 at 10:18 a.m. the IP stated they tried to have five CNAs complete hand washing check offs each week. They stated staff were to change gloves after removing soiled linen, after cleaning the resident, and when they were finished assisting the resident with peri-care. The IP stated staff were to place soiled linen in a dirty linen cart and not on the floor. On 05/06/25 at 1:23 p.m., the peri-care observation was reviewed with the IP. They stated, This is probably where some of our UTIs are coming from. 3. A January 2025 infection control color coded facility map showed 12 residents had skin infections and nine residents had UTIs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375527	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garland Road Nursing & Rehab Center	1404 North Garland Road Enid, OK 73703

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 - Some	A February 2025 infection control color coded facility map showed 13 residents had skin infections and nine residents had UTIs. A policy titled Infection Prevention, Control & Surveillance, revised February 2025, showed to look at the current month and preceding two months to determine similarities in infections. The policy showed to look for trends in common areas, residents with similar infections, and rooms close together. A March 2025 infection control color coded facility map showed 11 residents had skin infections and nine residents had UTIs. On 05/06/25 at 12:33 p.m., the IP stated they had not identified any trends in infections. On 05/06/25 at 1:23 p.m., January, February, and March 2025 infection control logs were reviewed with the IP. They stated they were counting the same bug. 46702 4. 04/29/25 at 12:11 p.m., a nebulizer machine with a tubing and mouth piece attached, and an oxygen concentrator with humidifier, dated 02/25/25, were observed bedside in the resident's room. The nebulizer mouth piece was laying on a bedside table not bagged and had moisture dripping onto papers on the table. There was no date on the oxygen tubing attached to the oxygen concentrator. A policy titled Respiratory Equipment Change Schedule, dated 01/12/18, read in part, The community will provide a schedule for changing disposable equipment at regular intervals as determined by manufacture recommendations and local community standards.For small volume medication nebulizer's, place in a clean bag, labeled with resident's name and if possible, leave at bedside. Resident #24's admission record, dated 01/11/24, showed they were admitted with diagnoses which included atherosclerotic heart disease of native coronary artery without angina pectoris, chronic kidney disease, COPD (chronic obstructive pulmonary disease), and obstructive sleep apnea. Resident #24's annual assessment, dated 08/20/24, showed their cognition was moderately impaired for decision making with a BIMS score of 10. Resident #24's physician orders, dated 09/30/24, read in part, ipratropium 0.5 mg-albuterol 3 mg (2.5 mg base)/3 mL [milliliters] nebulization soln [solution] (IPRATROPIUM BROMIDE/ALBUTEROL SULFATE) 1 VIAL Inhalation 3 times per day Duo nebs [nebulizer] INH [inhale] [at] 0800-1400 [2:00 p.m.]-2000 [8:00 p.m.] for SOB [shortness of breath]. Resident #24's physician orders, dated 03/11/25, read in part, O2 at 2 LPM [liters per minute] by NC [nasal cannula] AS NEEDED. Resident #24's physician orders, dated 04/04/25, read in part, Change Oxygen Cannula and tubing On Night Shift [Frequency: Weekly on Sunday Time: Shift 2]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375527	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/05/25 at 10:50 a.m., LPN #3 was asked to discuss Resident #24's respiratory needs. They stated the resident took breathing treatments with a nebulizer machine and had oxygen that was used as needed for shortness of breath. LPN #3 was asked what kind of infection control practices policies they had in place when using oxygen equipment and nebulizers. They stated the hand held nebulizer mouth piece should be bagged, dated, and changed weekly on Sundays. They stated the oxygen tubing got changed weekly, should be bagged when not in use, and the tubing should be dated. On 05/05/25 at 10:57 a.m., LPN #3 stated they observed Resident #24's side table was cluttered with a nebulizer mouth piece not in a bag laying on top of papers and the oxygen tubing attached to the concentrator did not have a date it was administered. On 05/05/25 at 11:06 a.m., the IP stated the infection control policies were not followed due to the nebulizer mouth piece on the side table not being bagged and the oxygen tubing was not labeled with a date it was replaced.