STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395429	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethlehem South Skilled Nursing and Rehabilitation	2021 Westgate Drive Bethlehem, PA 18017

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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. Based on facility policy review, clinical record review, observation, and staff interview, it was determined that the facility failed to assess a resident's capability to self-administer medications for one of 35 residents. (Resident 1)Findings include: Review of the facility policy entitled, Medications: Self-Administration, last reviewed on February 22, 2025, revealed that residents would be evaluated for self-administration of medications, would require a physician's order, and, when applicable, the resident would be provided with a secure, locked area to maintain medications. Clinical record review revealed that Resident 1 had diagnoses that included pneumonia, heart failure, and hypokalemia (low potassium level). Review of the Minimum Data Set (MDS) assessment, dated February 21, 2025, revealed that the resident's cognitive ability was intact. On September 4, 2025, between 11:21 a.m. and 11:37 a.m., Resident 1 was observed sleeping with one pill in a medication cup on the bedside table in front of her.In an interview on September 4, 2025, at 11:37 a.m., LPN 1 confirmed that the medication was potassium and that she had placed the medication in front of Resident 1 about 45 minutes to an hour before. There was no documentation to indicate that the facility had assessed Resident 1 for the ability to self-administer medications. The medication was not secured in her room. In an interview on September 5, 2025, the Director of Nursing confirmed that Resident 1 was not assessed to self-administer the medication as per the facility policy. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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
	395429	A. Building B. Wing	09/05/2025

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on facility policy review, personnel file review, and staff interview, it was determined that the facility failed to verify professional license/registration status prior to the start of employment for three of five newly hired employees. (Employees 1, 2, 3)Findings include: A review of the facility policy entitled, Abuse Prohibition, last reviewed February 27, 2025, revealed that the facility would implement an abuse prohibition program through screening of potential hires. The process included screening potential employees for a history of abuse, neglect, or mistreatment of patients which would have included checking with the appropriate licensing boards and registries. Review of personnel files of newly hired employees revealed the following: Employee 1 (E 1) began employment on August 12, 2025. There was no evidence that the facility submitted an inquiry to the state board of nursing before or since E 1 started working in the facility. E 2 began employment on July 29, 2025. There was no evidence that the facility submitted an inquiry to the state nurse aide registry before or since E 2 started working in the facility. E 3 began employment on June 10, 2025. There was no evidence that the facility submitted an inquiry to the state nurse aide registry before or since E 3 started working in the facility. In an interview on September 5, 2025, at 2:30 p.m., the Human Resources Manager confirmed that the inquiries were not submitted to the state board of nursing and sate nurse aide registry to screen the potential hires before the employees began working in the facility. 28 Pa. Code 201.14(a) Responsibility of licensee.

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	395429	A. Building B. Wing	09/05/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, and staff interview, it was determined that the facility failed to report an alleged violation of potential neglect for one of 35 sampled residents. (Resident 18) Findings include: Review of the facility policy entitled, Abuse Prohibitions, last reviewed February 27, 2025, revealed that the facility prohibited abuse, mistreatment, neglect, and exploitation, for all residents. The facility was to implement abuse prohibition through the following, to include reporting of incidents, investigations, and the facility's response to the results of their investigations immediately upon receiving information concerning a report of suspected neglect or abuse. The designee was to report the allegations involving neglect to the appropriate state and local authorities. Clinical record review revealed that Resident 18 had diagnoses that included chronic obstructive pulmonary disease, intellectual disabilities, and lumbago sciatica (pain in the lower back). The Minimum Data Set assessment dated [DATE], indicated that the resident had some memory impairment, required assistance of two staff for transfers and was totally dependent for bed mobility. A review of the care plan revealed that the resident was at risk due to a decreased ability to perform activities of daily living specifically bathing, grooming, and bed mobility related to limited mobility and interventions included assistance of two staff for bed mobility. Review of facility documentation dated July 29, 2025, revealed that the resident was found lying on the floor on his right side beside the bed. Further investigation revealed that the nurse aide who was providing care for him during the fall stated that she was turning him from his right side to his left side when his upper side of the body slid from the bed to the floor. There was a small bruise noted on his right shin and the right second toe nail was bleeding. There was no evidence that a second staff member was present to preform bed mobility, per the resident’s care plan. There was no documented evidence that the facility reported the incident of alleged neglect to the appropriate state and local agencies as per facility policy. In an interview on September 5, 2025, at 10:05 a.m., the Director of Nursing stated that the facility failed to report the incident of alleged neglect to the appropriate state and local agencies. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 201.29(a) Resident rights.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395429	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethlehem South Skilled Nursing and Rehabilitation	2021 Westgate Drive Bethlehem, PA 18017

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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 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on clinical record review and staff interview, it was determined that the facility failed to provide copies of written discharge or transfer notices to a representative of the Office of the State Long Term Care Ombudsman for eight of nine residents who were transferred out of the facility. (Residents 1, 3, 5, 9, 10, 12, 18, 66) Findings include: Clinical record review revealed that Resident 1 was transferred to the hospital on July 27, 2025, after a change in condition. There was no documented evidence that the facility sent copies of the written discharge or transfer notice to a representative of the Office of the State Long Term Care Ombudsman. Clinical record review revealed that Resident 3 was transferred to the hospital on August 7, 2025, after a change in condition. There was no documented evidence that the facility sent copies of the written discharge or transfer notice to a representative of the Office of the State Long Term Care Ombudsman. Clinical record review revealed that Resident 5 was transferred to the hospital on July 31, 2025, after a change in condition. There was no documented evidence that the facility sent copies of the written discharge or transfer notice to a representative of the Office of the State Long Term Care Ombudsman. Clinical record review revealed that Resident 9 was transferred to the hospital on August 7, 2025, after a change in condition. There was no documented evidence that the facility sent copies of the discharge or transfer notice to a representative of the Office of the State Long Term Care Ombudsman. Clinical record review revealed that Resident 10 was transferred to the hospital on July 28, 2025, after a change in condition. There was no documented evidence that the facility sent copies of the discharge or transfer notice to a representative of the Office of the State Long Term Care Ombudsman. Clinical record review revealed that Resident 12 was transferred to the hospital on April 26, 2025, and on April 29, 2025, after changes in condition. There was no documented evidence that the facility sent copies of the written discharge or transfer notices to a representative of the Office of the State Long Term Care Ombudsman for either date. Clinical record review revealed that Resident 18 was transferred to the hospital on July 11, 2025, and on August 10, 2025, after changes in condition. There was no documented evidence that the facility sent copies of the discharge or transfer notices to a representative of the Office of the State Long Term Care Ombudsman for either date. Clinical record review revealed that Resident 66 was transferred to the hospital on August 23, 2025, after a change in condition. There was no documented evidence that the facility sent copies of the written discharge or transfer notice to a representative of the Office of the State Long Term Care Ombudsman. (continued on next page)

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	395429	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethlehem South Skilled Nursing and Rehabilitation	2021 Westgate Drive Bethlehem, PA 18017

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	In an interview on September 5, 2025, at 11:00 a.m., the Director of Nursing confirmed that the written copies of the discharge or transfer notices were not sent to the Office of the State Long Term Care Ombudsman. 28 Pa. Code 201.14(a) Responsibility of licensee.

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	395429	A. Building B. Wing	09/05/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and staff interview, it was determined that the facility failed to ensure that appropriate assistance with oral hygiene was provided to one of 35 sampled residents. (Resident 7)Findings include: Review of the facility policy entitled, Oral Health, last reviewed on February 22, 2025, revealed that oral hygiene would be performed at a minimum of two times per day (morning and night). Clinical record review revealed that Resident 7 had diagnoses that included aphasia (a language disorder that affects a person's ability to communicate), right-sided weakness or paralysis due to a stroke, difficulty swallowing, and the presence of a feeding tube in the stomach. The Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident 7 was cognitively impaired, dependent on staff for Activities of Daily Living (ADLs), and did not eat by mouth. A review of the care plan revealed that the resident had an ADL self-care deficit related to physical limitations and interventions included to assist the resident with oral care as needed. Observations on September 4, 2025, between 11:27 a.m. and 12:15 p.m., revealed a large amount of thick yellow secretions on Resident 7's lips and inside his mouth, with two pools of thick green mucus on his bed sheets. Observation of Licensed Practical Nurse (LPN 1) on September 4, 2025 at 12:15 p.m. revealed LPN 1 was at Resident 7's bedside, but staff did not provide oral care. In an interview on September 4, 2025, at 1:00 p.m., Resident 7 indicated that he wanted to be cleaned. In an interview on September 5, 2025, at 12:40 p.m., the Director of Nursing confirmed that oral care was to be completed twice a day and as needed. CFR 483.24(a)(2) ADL care provided for Dependent ResidentsPreviously cited 11/27/24 28 Pa. Code 211. 12(d)(1)(5) Nursing services.

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	395429	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethlehem South Skilled Nursing and Rehabilitation	2021 Westgate Drive Bethlehem, PA 18017

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, and resident and staff interview, it was determined that the facility failed to provide necessary treatment and services to promote healing for one of three sampled residents who had pressure ulcers. (Resident 99) Findings include: Clinical record review revealed that Resident 99 had diagnoses that included multiple sclerosis, a chronic sacral pressure sore, and venous insufficiency. The Minimum Data Set assessment dated [DATE], indicated that the resident was alert, dependent on staff for activities of daily living (ADL), and had a stage four pressure ulcer. On May 13, 2025, the physician's order directed staff to remove the old dressing from the stage four pressure sore, provide cleaning to the sore, and apply packing and a new dressing to the sore daily and when the dressing became soiled. A review of a wound care physician's note dated September 3, 2025, documented the sacral pressure sore remained and directed staff to continue with treatment as ordered. A review of the care plan revealed that the resident was at risk for skin breakdown related to her decreased mobility, peripheral insufficiency, and fragile skin, and that she had a pressure sore. A review of the treatment administration records for July 1, 2025, through September 5, 2025, revealed a lack of documentation to support that the daily dressing was completed as ordered twice in September 2025, four times in August 2025, and four times in July 2025. In an interview on September 3, 2025, at 1:56 p.m., Resident 99 stated that her wound care was not always provided as ordered. In an interview on September 5, 2025, at 12:36 p.m., the Director of Nursing confirmed that there was no documented evidence that wound care was provided as ordered or that the resident refused the treatment on those dates. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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	395429	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethlehem South Skilled Nursing and Rehabilitation	2021 Westgate Drive Bethlehem, PA 18017

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and staff interview, it was determined that the facility failed to implement interventions to prevent further decline and/or improve range of motion for one of six sampled residents with limited range of motion. (Resident 15)Findings include: Clinical record review revealed that Resident 15 had diagnoses that included weakness or paralysis of the left side of the body due to a stroke and communication deficit. The annual Minimum Data Set (MDS) assessment dated [DATE], indicated that the resident was cognitively impaired, dependent on staff for dressing and personal hygiene, and had loss of range of motion. A review of Resident 15's care plan revealed the resident had a loss of range of motion of the left upper extremity. On December 19, 2024, the physician ordered that staff apply a palm guard (a device applied to protect the palm of the hand) to Resident 15's left hand in the morning and remove in the evening. Observations on September 3, 2025, between 10:05 a.m. and 1:45 p.m., and September 4, 2025, between 11:16 a.m. and 2:50 p.m., revealed that Resident 15 was without a palm guard on his left hand. In an interview on September 5, 2025, at 12:40 p.m., the Director of Nursing confirmed that the palm guard was to be on as ordered by the physician. CFR 483.25(c)(1)(3) Increase/Prevent Decrease In Range of Motion/Mobility Previously cited 11/27/24. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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	395429	A. Building B. Wing	09/05/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review and resident and staff interview, it was determined that the facility failed to provide adequate treatment and services for respiratory therapy and failed to maintain respiratory equipment in a sanitary manner for four of six sampled residents who utilized respiratory equipment. (Residents 1, 7, 12, 104)Findings include: Review of the facility policy entitled, Respiratory Equipment/Supply Cleaning/Disinfecting, last reviewed February 27, 2025, revealed that the schedule for supply changes for oxygen humidifiers was to be every seven days and as needed for soiling and nebulizer equipment was to be changed daily. Clinical record review revealed that Resident 1 had diagnoses that included pneumonia, asthma, and respiratory failure. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed that the resident was alert and oriented and that she utilized oxygen therapy. A physician's order dated July 31, 2025, directed staff to administer a medication that relaxes muscles in the airway to increase airflow to the lungs (levalbuterol HCl inhalation nebulization solution) four times a day for asthma. A physician's order dated August 11, 2025, directed staff to administer oxygen at two liters (L) via nasal cannula (a thin flexible tube that carries oxygen and has two prongs to fit into the nostrils) to maintain oxygen saturation levels (a percentage value indicating how much oxygen is in your blood) at 90 percent (%) or above. A review of the care plan identified that Resident 1 was at risk for respiratory complications due to asthma and acute respiratory failure and included application of nebulizer and oxygen as ordered. Observation on September 3, 2025, at 9:55 a.m., revealed that the resident had a humidification bottle on the oxygen concentrator that was not dated. The nebulizer tubing was dated August 25, 2025. Clinical record review revealed that Resident 7 had diagnoses that included chronic obstructive pulmonary disease (COPD) (an inflammation and damage to the airways and lungs that leads to breathing difficulties), respiratory failure, and low oxygen in the blood. Review of the MDS assessment dated [DATE], revealed that the resident was cognitively impaired and that he utilized oxygen therapy. A physician's ordered dated February 26, 2025, directed staff to administer oxygen at two liters per minute (L/min) via nasal cannula every shift. A review of the care plan identified that he was at risk for respiratory complications due to diminished lung sounds. Observation on September 4, 2025, at 11:27 a.m., revealed that the humidification bottle attached to the oxygen concentrator was not dated and the oxygen tubing was dated August 24, 2025. Clinical record review that Resident 12 had diagnoses that included pneumonia, COPD, and chronic respiratory failure. Review of the MDS assessment dated [DATE], revealed that the resident was cognitively intact and utilized oxygen therapy. A physician's order dated May 28, 2025, directed staff to administer oxygen via nasal cannula at three L/min continuous every shift for COPD. A review of the care plan identified that she was at risk for respiratory complications due to COPD. Observation on September 3, 2025, at 10:25 am, revealed that the resident was using a portable oxygen tank via nasal cannula and the oxygen tubing was not dated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395429	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethlehem South Skilled Nursing and Rehabilitation	2021 Westgate Drive Bethlehem, PA 18017

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Clinical record review revealed that Resident 104 had diagnoses that included COPD and sleep apnea. Review of the MDS assessment dated [DATE], revealed that the resident was alert and oriented and that she utilized oxygen therapy. A physician’s order dated March 4, 2025, directed staff to administer oxygen at two L/min via nasal cannula every shift, as needed, to maintain oxygen saturation levels at 90% or above, and to administer oxygen at three L/min in the evenings and overnight for sleep apnea. A review of the care plan identified that she was at risk for respiratory complications due to COPD. There was an intervention for her to receive oxygen at two liters as needed and three liters at night. In an interview on September 4, 2025, at 10:35 a.m., Resident 104 stated that her oxygen humidifier bottle was very low and that she did not feel that the humidifier bottle was changed enough. She further stated that if the water was low or empty it affected her ability to breathe normally. Resident 104 stated that the last time the humidifier was changed was August 17, 2025. Observation on September 4, 2025, at 11:30 a.m., revealed that the resident had an oxygen concentrator in her room. The bag on the concentrator for the nasal canula was dated August 17, 2025, and the humidifier bottle was almost empty. In an interview on September 5, 2025, at 11:07 a.m., the Director of Nursing stated that oxygen tubing and humidifier bottles were to be changed every seven days and as needed and nebulizer tubing was to be changed on a daily basis. 28 Pa. Code 211.12 (d)(1)(5) Nursing services.