STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396151	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tunkhannock Rehabilitation & Health Care Center	27 West Street Tunkhannock, PA 18657

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 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 review of the Resident Assessment Instrument (RAI) Manual, clinical records, and staff interviews, it was determined that the facility failed to complete an accurate Minimum Data Set (MDS) for two of 13 residents sampled (Residents 2 and 45).Findings include: The Long-Term Care Facility RAI User's Manual, which provides instructions and guidelines for completing the Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated October 2025, requires that each MDS assessment accurately reflect the resident's status during the assessment reference period (the specific look-back period of days the assessor must review). The Manual requires that a registered nurse conduct or coordinate each assessment with participation of appropriate health professionals. The assessment process must include direct observation of the resident and communication with the resident and direct care staff on all shifts. A clinical record review revealed Resident 2 was admitted to the facility on [DATE], with diagnoses that included unspecified dementia (also known as mixed dementia, is a form of dementia that is characterized by a combination of two or more types of dementia where the individual experiences symptoms that are typically seen in different types of dementia, making it difficult to diagnose and treat), hemiplegia (paralysis on one side of the body), and hemiparesis (weakness on one side of the body), cerebrovascular disease (a disorder affecting blood flow to the brain, often resulting in stroke) and moderate protein-calorie malnutrition (occurs when the body does not receive enough protein and calories to maintain proper health and functioning. It is common among terminally ill patients due to numerous factors, such as reduced appetite, difficulty eating, and weakened immune system). A physician's order dated June 25, 2025, at 4:21 PM, directed the use of right and left quarter side rails in bed as enablers. Quarter side rails are short bed rails that extend along a portion of the bed. Bed rails may be considered a restraint if they restrict a resident's freedom of movement or ability to voluntarily get out of bed. A review of Resident 2's quarterly MDS assessment dated [DATE], revealed the assessment was coded to indicate the resident required substantial to maximal assistance to roll from left to right while lying on her back in bed and with transfers between bed and chair. Section P-P0100 (Restraints and Alarms Used in Bed) was coded to indicate the resident had bedrails in place daily as a form of restraint. Section P of the MDS captures the use of physical restraints. A physical restraint is defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that restricts freedom of movement or normal access to the body and that the resident cannot remove easily. Clinical record review revealed the resident had right and left quarter side rails in place. The clinical record failed to demonstrate documentation that the quarter side rails restricted the resident's freedom of movement, prevented voluntary exit from the bed, or otherwise met the definition of a restraint. The record also lacked documentation identifying the quarter side rails as a restraint or providing clinical justification for coding them as such in Section P. During an interview with the Nursing Home Administrator (NHA) on October 23, 2025, at 2:10 PM, the above information was reviewed. At that time, it was acknowledged that Resident 2's quarterly MDS dated [DATE], Section P- P0100 (Restraints), had been coded to indicate the presence of a restraint, and the coding was identified as an error. A clinical (continued on next page)

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
	396151	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tunkhannock Rehabilitation & Health Care Center	27 West Street Tunkhannock, PA 18657

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record review revealed Resident 45 was admitted to the facility December 3, 2025, with diagnoses that included acute and chronic respiratory failure with (a condition in which the lungs cannot adequately exchange oxygen and carbon dioxide, resulting in low blood oxygen levels). A review of the Resident 45's admission MDS dated [DATE], section N (section addressing medications including high risk drug classes including antipsychotic, antianxiety, and antidepressants) Section N0415, High-Risk Drugs Use and Classification documented Resident 45 was not administered antipsychotic drugs (medications used to treat a collection of symptoms that affect the ability to tell what's real) during the assessment reference period. Section N0450 (Antipsychotic Medication Review) indicated the resident had not received antipsychotic medication since admission. A review of Resident 45's physician orders revealed an order dated December 3, 2025, for Quetiapine Fumarate Oral Tablet 25 mg (antipsychotic medication), one tablet by mouth at bedtime for depression with behaviors. Medication Administration Record review confirmed Resident 45 received Quetiapine Fumarate 25 milligrams nightly during the assessment reference period of December 3, 2025, through December 9, 2025. During an interview on February 19, 2026, at 1:10 PM, the Registered Nurse Assessment Coordinator (RNAC) acknowledged the admission MDS dated [DATE], did not accurately reflect the resident's routine daily use of an antipsychotic medication since admission. 28 Pa. Code 211.5(f)(iii) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396151	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tunkhannock Rehabilitation & Health Care Center	27 West Street Tunkhannock, PA 18657

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on select facility policy, a review of clinical records, the Resident Assessment Instrument (RAI) manual, and staff interviews, it was determined the facility failed to follow the care plan process after the completion of a comprehensive assessment for one out of 13 residents sampled (Resident 8).Findings include: A review of facility policy entitled Resident Care Planning Requirements (reviewed April 8, 2025) revealed the facility will develop and implement a person-centered care plan that supports the residents' highest practicable physical, mental, and psychosocial well-being. The policy further indicated a comprehensive care plan, and a care plan meeting will be held seven days after a comprehensive Minimum Data Set (MDS, a federally mandated standardized assessment conducted at specific intervals to plan resident care) assessment. According to the facility policy, the MDS Coordinator will schedule the interdisciplinary team (IDT) meeting within required time frames. The Resident Assessment Instrument (RAI) (2025, October) manual is a standard tool published by the federal government and serves as a guide for completing accurate, timely resident assessments and care plan processes. According to the RAI manual, a significant change in status MDS assessment is a comprehensive assessment required when a nursing home resident enrolls in a hospice program (specialized model of care for a resident with a terminal illness that focuses on comfort and quality of life). The comprehensive assessment ensures a coordinated plan of care exists between hospice and the facility according to the RAI manual. A comprehensive care plan must be developed by an IDT (interdisciplinary team) including but not limited to the attending physician, registered nurse with responsibility for the resident, the resident and / or representative and other staff or professionals as determined by the resident needs (e.g. hospice). The care plan completion date cannot be later than seven days after completion of the comprehensive assessment. A review of Resident 8's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including dementia (loss of cognitive functioning including thinking, remembering, and reasoning to an extent that it interferes with daily life), hyperlipidemia (high levels of fats in the blood), and anxiety (feelings of worry, unease, nervousness). A review of physician orders revealed an order dated November 11, 2025, for Resident 8 to be admitted to hospice services with the diagnosis of end stage senile degeneration of the brain (the brain is the final stage of dementia when significant and permanent damage of the brain exists). The clinical record revealed a comprehensive Significant Change Minimum Data Set (MDS) assessment dated [DATE], and reflected hospice services for Resident 8. However, the clinical record lacked documentation of the comprehensive, IDT care plan process completed within seven days of the comprehensive MDS. The record lacked evidence of a documented IDT meeting involving the physician, registered nurse, resident and/ or representative, and other disciplines relevant to Resident 8's care, care plan revision, or documentation reflecting integration of hospice services into the comprehensive care plan during the required timeframe.During an interview on February 19, 2026, at 2:00 PM, the Social Service Worker confirmed the facility could not provide documentation to support that an interdisciplinary care plan meeting occurred within seven days after completion of the comprehensive MDS assessment. The absence of an interdisciplinary care plan meeting communicating the integration of hospice care for Resident 8 contradicts the facility policy and RAI manual emphasizing the care plan process must be interdisciplinary and completed within seven days following a comprehensive assessment. During a subsequent interview on February 19, 2026, at 2:15 PM, the Nursing Home Administrator and Director of Nursing reviewed the above findings and acknowledged the facility did not complete an interdisciplinary care plan meeting after the Significant Change MDS dated [DATE]. 28 Pa. Code 211.5(f)(iii) Medical records. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396151	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tunkhannock Rehabilitation & Health Care Center	27 West Street Tunkhannock, PA 18657

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of select facility policy, a review of clinical records, and staff interviews, it was determined the facility failed to monitor resident weights consistently and accurately to timely identify changes in nutritional parameters and implement nutritional interventions for one resident out of 13 residents sampled (Resident 2).Findings include: A review of a facility policy entitled Resident Heights and Weight Policy last reviewed by the facility April 8, 2025, indicated residents will be weighed upon admission to facility and on day two after admission. After the second day weight, all newly admitted residents will be weighed weekly for four weeks and then on a monthly basis unless otherwise specified. The resident weights will be recorded in the electronic medical record. Reweights will be obtained for any residents whose weight fluctuations by plus or minus five pounds (lbs.) for those over 100 lbs. and plus or minus three pounds for those weighing less than 100 pounds. The licensed nurse will notify the Director of Nursing or designee, Physician, and Registered Dietitian of significant weight changes of 5 percent loss or gain in one month, or a 7.5 percent loss or gain in 3 months, or a 10 percent loss of gain in 6 months. Notify the resident's representative regarding significant weight loss and any recommendations from the resident's provider and registered dietitian. The registered dietitian will notify the charge nurse of any significant weight changes and follow up with documentation in the resident's medical record. Review of the facility policy titled Weight Assessment and Intervention, last reviewed April 8, 2025, indicated that for any weight change of five percent or more since the last assessment, a reweight would be obtained the next day for confirmation. A clinical record review revealed Resident 2 was admitted to the facility on [DATE], with diagnoses that included unspecified dementia (also known as mixed dementia, is a form of dementia that is characterized by a combination of two or more types of dementia where the individual experiences symptoms that are typically seen in different types of dementia, making it difficult to diagnose and treat), hemiplegia (paralysis on one side of the body), and hemiparesis (weakness on one side of the body), cerebrovascular disease (a disorder affecting blood flow to the brain, often resulting in stroke) and moderate protein-calorie malnutrition (occurs when the body does not receive enough protein and calories to maintain proper health and functioning. It is common among terminally ill patients due to numerous factors, such as reduced appetite, difficulty eating, and weakened immune system). A review of Resident 2's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated June 23, 2025, revealed Resident 2 was moderately cognitively impaired with a BIMS score of 10 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 8 through 12 indicates moderate cognitive impairment) was not on a therapeutic diet, and able to self-feed after set-up. Resident 2's comprehensive care plan, initiated June 17, 2025, identified the resident at risk for nutritional decline related to dementia, hemiplegia, hemiparesis, moderate protein calorie malnutrition, and a history of pressure wounds. The care plan identified the desired outcome that the resident would maintain adequate nutritional status as evidenced by stable weight without significant weight changes. The plan directed staff to monitor, record, and report to the physician as needed signs and symptoms of malnutrition, including emaciation, (extreme thinness resulting from significant loss of body fat and muscle mass); muscle wasting; weight loss of three pounds in one week; greater than five percent in one month; greater than 7.5 percent in three months; and greater than 10 percent in six months. Additional interventions included providing the diet as ordered and requiring the Registered Dietitian (RD) to evaluate the resident and make diet change recommendations as needed. A review of a nutritional assessment completed by the facility's Registered Dietitian dated June 17, 2025, documented that Resident 2 was ordered a regular diet with regular texture and thin liquids and was not prescribed oral nutritional supplements at that time. The (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396151	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tunkhannock Rehabilitation & Health Care Center	27 West Street Tunkhannock, PA 18657

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Dietitian documented a height of 60 inches and a weight of 152.4 pounds. Estimated nutritional needs were calculated at 1500 calories per day, 59 grams of protein per day, and 1500 milliliters of fluids per day, with staff instructed to encourage fluid intake. The assessment documented the resident's Body Mass Index was in the overweight range. Body Mass Index is a numerical value calculated from a person's height and weight that is used as a screening tool to categorize weight status and assess potential health risk. Despite the Body Mass Index classification, the Registered Dietitian identified the resident as at risk for malnutrition due to underlying diagnoses and documented fair meal intake with continued monitoring planned. Review of the weight record revealed the following:On June 16, 2025, at 1:24 PM, the admission weight was recorded as 129.4 pounds. The facility did not obtain weekly weights on June 23, 2025, or July 1, 2025, as required by policy. The next recorded weight occurred three weeks later on July 7, 2025, at 12:35 PM, at 130 pounds. No additional weight was recorded until August 5, 2025, at 7:10 PM, at 119.6 pounds. This reflected a weight loss of 10.4 pounds from July 7, 2025, which equals approximately eight percent weight loss in one month and met the facility's definition of significant weight loss. The facility did not obtain a reweight the next day as required by policy. The next weight was obtained seven days later on August 12, 2025, at 7:40 PM, and again recorded 119.6 pounds, confirming significant weight loss of 10.4 lbs. or 8 percent in one month. The clinical record did not reveal documentation that the Registered Dietitian identified and addressed the significant weight loss between July 7, 2025, and August 5, 2025. A nutrition/dietary note dated August 12, 2025, at 11:19 AM, documented awareness of new wounds and fair intake and recommended liquid protein twice per day to support healing. It was indicated the physician and responsible party were made aware. The record did not demonstrate timely development and implementation of additional nutritional interventions following identification of significant weight loss and development of wounds. On August 12, 2025, following identification of significant weight loss, the facility updated Resident 2's comprehensive care plan to include nutritional interventions. The care plan documented initiation of Prosource daily, (a concentrated liquid protein supplement intended to increase dietary protein intake); Magic Cup, (a high calorie, high protein nutritional supplement served as a frozen dessert); and Ensure daily, (a commercially prepared high calorie, high protein oral nutrition supplement designed to promote weight stability). The care plan was later revised on February 19, 2026, during the onsite survey. Despite documenting these interventions in the care plan, the facility was unable to provide documented evidence demonstrating timely implementation of Magic Cup or Ensure supplementation following the resident's significant weight loss and development of wounds. A dietary progress note completed by the Registered Dietitian on August 31, 2025, documented that Resident 2 had experienced significant weight loss and remained on liquid protein supplementation for wound healing. The note indicated fluctuating meal intake and documented that family members were providing additional meals and encouragement with intake. The RD documented continued monitoring and consideration of additional supplementation at follow up. The weight record revealed that no weights were obtained between August 12, 2025, and September 17, 2025. On September 18, 2025, at 8:56 AM, a quarterly nutrition assessment revealed the Registered Dietitian documented the most recent available weight as 119.6 pounds from August 12, 2025, reflecting a 10.4 pound loss and triggering for significant weight loss. The assessment noted the resident remained at risk for malnutrition with fair meal intake. Later that same day, at 7:48 PM, nursing staff recorded a weight of 117.4 pounds, demonstrating continued weight decline. A follow up dietary note dated September 30, 2025, at 12:26 PM, documented that the resident's weight continued to decrease with fair to poor meal intake. The Registered Dietitian noted that family continued to provide snacks and additional food. The liquid protein supplement continued, and the Registered Dietitian recommended adding Magic Cup once daily to promote increased oral intake. On October 6, 2025, at 2:02 PM, the resident's weight was recorded at 114.6 pounds. On October 9, 2025, at 2:03 PM, a dietary progress note documented that the resident continued to trigger for significant weight loss and that weight (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396151	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tunkhannock Rehabilitation & Health Care Center	27 West Street Tunkhannock, PA 18657

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	continued to trend downward. The note indicated that Magic Cup had recently been added and recommended initiation of Ensure once daily to further promote oral nutrient intake and weight stability. On November 1, 2025, at 2:34 PM, the resident's weight was recorded at 110.6 pounds, reflecting ongoing decline. A dietary progress note dated November 6, 2025, at 12:07 PM, documented continued significant weight loss and indicated Ensure had been added in addition to Magic Cup approximately one month earlier. The note documented that the resident was accepting supplementation with variable meal intake. Review of the clinical record failed to demonstrate timely development and documented implementation of Magic Cup and Ensure supplementation following the initial identification of significant weight loss in August 2025. The record reflected progressive weight decline and ongoing wound concerns without evidence that ordered nutritional interventions were implemented in a timely manner to prevent further deterioration. During an interview on February 19, 2026, at 2:15 PM, the Nursing Home Administrator and Director of Nursing reviewed the findings and confirmed the facility could not provide additional documentation demonstrating timely weight monitoring, timely reweights as required by policy, or timely implementation of oral nutritional supplementation to address Resident 2's progressive weight loss and associated wound development. 28 Pa Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (c) (d)(3)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396151	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tunkhannock Rehabilitation & Health Care Center	27 West Street Tunkhannock, PA 18657

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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of select facility policy, observations, clinical record review, and resident and staff interviews, it was determined the facility failed to ensure oxygen therapy was administered in accordance with physician orders and professional standards for two residents out of eight residents sampled (Resident 45 & Resident 29).Findings include:A review of the facility policy titled Oxygen Administration last reviewed by the facility on April 8, 2025, revealed it is the facility's policy to provide oxygen therapy in a safe manner consistent with physician orders and the resident's care plan. A clinical record review revealed Resident 45 was admitted to the facility December 3, 2025, with diagnoses that included acute and chronic respiratory failure with hypoxia (condition in which the lungs cannot exchange gases, leading to low oxygen levels). A physician orders initially date December 3, 2025, included administration of oxygen at 3 liters (L) per minute via nasal cannula (small flexible tube with two short prongs placed in the nostril to provide oxygen). The physician orders indicated to change the oxygen tubing and humidifier (the cylinder device used to keep the air from the source of oxygen moist) weekly. A review of the Resident 45's plan of care initiated January 19, 2026, revealed the resident had underlying respiratory status. The identified goal was for Resident 45 to be free from signs of respiratory infection and maintain adequate breathing patterns daily. Interventions included monitoring for signs of respiratory infection including confusion and restlessness, providing assistance with changing Resident 45's position to support movement of air and fluid through the lungs and administering oxygen by a nasal cannula continuously. An observation on February 18, 2026, at 10:45 AM, revealed Resident 45 was awake sitting in her wheelchair in a common resident area. Resident 45 was observed to be receiving oxygen by a nasal cannula connected to an oxygen tank on the back of Resident 45's wheelchair. The oxygen tubing connecting Resident 45 from the nasal cannula to the oxygen tank was dated February 5, 2026, exceeding the seven-day (weekly) duration as ordered. During an interview on February 18, 2026, at 11:33 AM, Employee 1, Registered Nurse (RN), confirmed Resident 45's oxygen tubing should have been replaced every seven days and the date on the tubing (February 5) exceeded the seven-day duration as per the physician orders. The above information was reviewed during an interview on February 18, 2026, at 2:30 PM, with the facility DON and Administrator. A review of Resident 29's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included Relapsing Remitting Multiple Sclerosis, (an autoimmune condition that affects the central nervous system where the immune system attack's the myelin, the protective cover over nerve fibers including those of the brain and spinal cord, causing inflammation and nerve damage). A review of the clinical record revealed a physician's order dated July 2,2025, for Oxygen at 2L/min via Nasal cannula PRN (as needed) for SOB (shortness of breath). Check liter flow and placement every four hours. Further review revealed a physician's order dated July 2,2025, to change the oxygen tubing, bubble humidifier, rinse filter and date tubing and humidifier weekly. An observation on February 18 ,2026 at 1:18 PM revealed the nasal canula tubing that the resident was using was dated February 5, 2026. During the same observation, a clear plastic bag used for storing oxygen tubing was noted with the date of February 5, 2026, written on the front of the clear plastic bag. An interview with Employee 1 RN confirmed the tubing and bag were dated February 5,2026. An interview was conducted with the Director of Nursing (DON) on February 18,2026, at 2:15 PM to review the above findings related to the facility's failure to maintain respiratory equipment in a manner to promote optimal functioning. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.