

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455725	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Oakmont Healthcare and Rehabilitation of Humble		STREET ADDRESS, CITY, STATE, ZIP CODE 8450 Will Clayton Pkwy Humble, TX 77338	
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 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 provide a safe, clean, comfortable and homelike environment for residents, staff, and the public, for 2 of 21 resident rooms (Resident #39 and #28) reviewed for physical environment. The facility failed to maintain clean privacy curtains for Resident #39 and clean bed linen for an unoccupied bed in Resident #28's room. This failure could lead to residents experiencing a diminished quality of life. Findings included: Record review of Resident #39's face sheet dated 02/26/26 revealed a [AGE] year-old admitted to the facility on [DATE]. His diagnoses included stroke, contractures, Hemiplegia (one sided paralysis or severe loss of strength on one side), diabetes (a chronic condition that occurs when blood glucose levels are too high) and peripheral vascular disease (a disorder of blood vessels outside the heart that affects blood flow to the limbs). Record review of Resident #39's quarterly MDS dated [DATE] revealed a BIMS score of 8 out of 15 indicating moderate cognitive impairment. He required substantial assistance with all ADLs and he was frequently incontinent of bowel and bladder. Record review of Resident #28's face sheet dated 02/26/26 revealed a [AGE] year-old admitted to the facility on [DATE]. Her diagnoses included dementia (a general term for a group of symptoms that cause a loss of cognitive functioning), depression, anxiety, gastrostomy status (presence of abdominal feeding tube), colostomy status (presence of abdominal appliance to collect waste to manage bowel function), stroke, hemiplegia (paralysis or severe loss of strength on one side) and pressure ulcers. Record review of Resident #28's quarterly MDS dated [DATE] revealed a BIMS score of 3 out of 15 indicating severe cognitive impairment. Resident #28 required maximum assistance from staff for all ADLs. Observation on 02/25/26 at 8:20 AM of the privacy curtain for Resident #39 revealed it had multiple large orange-brown stains. Observation on 02/25/26 at 10:45 AM, Resident #28 had an unoccupied bed in the room. The white bedspread had multiple brown and black stains. Observation and interview on 02/26/26 at 7:30 AM revealed the privacy curtain had multiple large orange-brown stains. Resident #39 stated the curtain was dirty and needed to be changed. CNA V stated that the privacy curtain had stains and should be clean. CNA V stated that if privacy curtains needed attention, she would notify maintenance to bring it down off the hooks and laundry to bring clean curtains for replacement. In an interview on 02/26/26 at 11:35 AM, the Housekeeping Supervisor stated that the privacy curtain in Resident #39's room had multiple yellow/orange stains and should be changed out because it was an infection control issue. The Housekeeping Supervisor stated the unoccupied bed in Resident #28's room had stains and she could not tell if the blanket had ever been washed. The Housekeeping Supervisor stated that the blanket should have never even made it on the clean linen cart and should not have been used to make up the bed because it did not look clean and would leave a bad impression. The Housekeeping Supervisor stated that if it was her loved one and saw the bed with a blanket with stains, she would feel bad about the facility. In an interview on 02/26/26 at 11:40 AM, the Administrator stated she oversees the housekeeping department. The Administrator stated she expected housekeepers when making rounds to report dirty privacy curtains or dirty bedding covers to the Housekeeping Supervisor. The Administrator stated she also expected facility staff to make their (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 19%, based on 5 errors out of 26 opportunities, which involved 2 of 6 residents (Resident #26 and #28) and 2 of 4 staff (LVN J and LVN D) observed during medication administration reviewed for medication errors. LVN J administered insulin to Resident #26 at the incorrect time according to the facility MAR. LVN D failed to flush with water between medications during g-tube administration for Resident #28. These failures could place residents at risk of not receiving the desired therapeutic effect of their medications. Findings include: Resident #26 Record review of Resident #26's admission record dated 2/26/26 revealed a [AGE] year-old male who admitted on [DATE]. His diagnoses included type 2 diabetes (a chronic condition characterized by insulin resistance and high blood sugar levels), hyperglycemia (high blood sugar), and moderate protein-calorie malnutrition. Record review of Resident #26's quarterly MDS assessment dated [DATE] revealed a BIMS score of 1 out of 15 which indicated severe cognitive impairment. He required assistance from staff with ADL care and was on insulin. Record review of Resident #26's order summary report revealed an order for Humalog Kwikpen inject as per sliding scale: if 150-200 = 0 monitor; 201-250 = 2U; 251 - 300 = 4U; 301 - 350 = 6U; 351-400 = 8U; 401-450 = 10U; 451-500 = 15U notify provider, two times a day for diabetes related to type 2 diabetes, order date 1/14/26. Record review of Resident #26's February 2025 MAR revealed the Humalog Kwikpen per sliding scale was scheduled twice a day for AM and PM. 8 units of Humalog was marked as administered on 2/25/26 by LVN J for the AM dose for a blood sugar level of 382. Record review of the facility's undated Medication Administration Times revealed AM times were 6:30 a.m. - 10:30 a.m.; Midday was 11:00 a.m. - 2:00 p.m.; afternoon was 6:00 p.m. - 10:00 p.m. and bedtime was 8:00 p.m. - 10:00 p.m. In an observation on 2/25/26 at 11:01 a.m. LVN J retrieved Resident #26's blood sugar which was 463. She reviewed Resident #26's insulin orders on his order sheet but did not reference the electronic MAR. She administered 15 units of Insulin lispro (Humalog) to Resident #26. LVN J pulled up the electronic MAR to document the insulin as administered but the Humalog insulin was colored green (which indicated the medication was already administered). LVN J said she already administered insulin to Resident #26 this morning when his blood sugar was 383. She said nurses rechecked Resident #26's blood sugar around lunch time if his blood sugar ran over 250 in the morning and would administer insulin according to the sliding scale. She said she should have called Resident #26's NP first to get an order to administer the insulin but there was no order to check his blood sugar or give insulin at this time. She said prior to administering medication she usually reviewed the eMAR to see what medication to give. She said there was no risk to the resident because his blood sugar level was high. Resident #28 Record review of Resident #28 admission record dated 2/25/26 revealed a [AGE] year-old female who readmitted on [DATE]. Her diagnoses included dementia, gastrostomy status (a surgically created opening into the stomach, typically with a feeding tube (G-tube) in place for nutrition, hydration, or medication delivery), hypotension (low blood pressure), generalized anxiety disorder, and epilepsy (chronic brain disorder characterized by recurrent unprovoked seizures). Record review of Resident #28's discharge MDS assessment dated [DATE] revealed her cognitive level was not assessed. She was dependent on staff for ADL care and had a feeding tube. Record review of Resident #28's care plan completed on 11/12/25 revealed she required a tube feeding related to swallowing problem, late effects of CVA. Interventions: the resident is dependent on tube feeding and water flushes. See MD orders for current feeding orders. Record review of Resident #28's order summary report revealed orders for: Enteral feed order every shift flush enteral tube with at least 10 mls of water between each medication, order date 9/17/25; Gabapentin 100 mg 1 capsule via g-tube three times a day for nerve pain, order date 1/19/26, Midodrine 2.5 mg 1 tablet via g-tube three times a day for hypotension, order date 8/13/25, Lorazepam (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1 mg 1 tablet via PEG tube three times a day for anxiety, order date 11/8/25, Valproate sodium oral solution 250 mg/5 mL give 3 mL via g-tube three times a day for seizure, order date 8/13/25. In an observation on 2/25/26 at 1:05 p.m. revealed LVN D prepared the following medications for Resident #28: Gabapentin 100 mg, Midodrine 2.5 mg, Lorazepam 1 mg, and Valproate acid 3 mL. LVN D entered Resident #28's room and began medication administration via g-tube to Resident #28. LVN D checked for g-tube placement and residual. She administered the four medications without flushing with water in between each one. After administering the last medication, she flushed the tube with 30 mL of water. LVN D said she forgot the water flush in between the medications and said she did not have an order to flush with water in between the medications. After completing the medication pass, LVN D exited the room and began to document the medication administration on the computer. She reviewed the medication orders for Resident #28 and when the order for flush enteral tube with at least 10 mL of water between each medication appeared, she said she got nervous and forgot to flush between each medication. In an interview on 2/26/26 at 10:22 a.m. the interim DON said medications should be given per order. She said nursing staff should ensure they review the physician order from the eMAR to ensure the medication matches and is provided at the right time. She said the PM timeframe was scheduled from 6:00 p.m. - 10:00 p.m. She said g-tube medications should be flushed per the MD order and the purpose of the water flush in between medications was to ensure all medication has gone through the tubing. In an interview on 2/26/26 at 11:34 a.m. the Administrator said she expected the medication error rate to be 5% or less. She said medication passes were a part of the rapid response team. Record review of the facility's Medication Administration and General Guidelines dated 2025 read in part, .Medications are administered as prescribed, in accordance with State Regulations using good nursing principles and practices and only by persons legally authorized to do so. Medications are administered in accordance with written orders of the attending physician. 6. All current medications and dosage schedules, except topicals used for treatments, are listed on the resident's medication administration record (MAR). 10. Medications are administered within one hour of the scheduled time, unless the physician specifies a specific time then the med must be given 30 minutes prior to 30 minutes after the specified time (unless facility policy directs otherwise). Before or after meal orders are administered precisely as ordered. Unless otherwise specified by the physician, routine medications are administered according to the established medication administration schedule for the facility. Checklist for completing proper steps in the administration of medications. Adheres to the 6 Rights of Medication Administration. 5) Right Time. Record review of the facility's Enteral Tube Medication Administration dated 2025 read in part, .The facility assures the safe and effective administration of enteral formulas and medications. 7. Read medication label three times before administering, checking with MAR. Administer each medication separately, flushing tube with 5-15 ml of water after each dose.		

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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 observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights set forth to attain or maintain the residents highest practicable physical, mental, and psychosocial needs and well-being for 1 of 14 (Resident #69) residents. The facility failed to ensure that Resident #69's care plan documented interventions for hand contractures. This failure could result in residents being at risk and not receiving proper care. Findings included: Record review of Resident #69's undated admission record revealed a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included multiple sclerosis (long lasting disease or central nervous system), tremor, muscle weakness, lack of coordination (muscle control problem), mild cognitive impairment, and muscle spasm. Record review of Resident #69's SBAR Assessments for dates ranging 07/16/2024-02/23/2026 did not reveal a change in condition for left hand contracture. Record review of Resident #69's MDS Quarterly assessment dated [DATE] revealed a BIMS score of 10 out of 15 indicating he had moderately impaired cognition. He had impairment on one side to the upper extremity (shoulder, elbow, wrist, hand) and no impairment on both sides to the lower extremity (hip, knee, ankle, foot). Record review of Resident #69's MAR revealed an order for Cyclobenzaprine 10mg tablets, one tablet three times a day for multiple sclerosis, Baclofen 10mg tablets, one tablet three times a day for muscle spasms, and Propranolol 20mg tablets, one tablet two times a day for tremor. Record review of Resident #69's Care Plan dated 08/20/2024 did not identify interventions for contracted left hand. In Observation and Interview on 02/25/2026 at 10:12am Resident #69 was observed lying in bed with a left-hand contracture without a brace in place. Resident #69 stated he sometimes experiences pain in his left hand and is unable to fully open it. Resident #69 stated he was not receiving therapy at this time and began to dose off. In an interview with DOR on 02/25/2026 at 11:28am she stated she was recently made aware of Resident #69's left hand contracture and he is currently being trialed with a splint every day for one hour. Resident #69 was recently placed on therapy case load three times a week for the hand contracture and when the services are discharged, he will be recommended to wear a splint up to four hours, daily. At this time, the contracture concern is being actively addressed to prevent potential harm. In an interview with LVN J on 02/25/2026 at 12:28pm she stated she has noticed the left-hand contracture for Resident #69, because the staff has been setting up the tray for him to eat. LVN J stated the resident was admitted to the facility with the left hand contracted, and he does not complain of pain, but if he was to complain, he has been prescribed PRN Norco. To her knowledge the resident was admitted with the contracture, which should be indicated in the care plan, although she has not noticed a decline in his hand usage. Should the contracture not be care planned, she would reassess for a change in condition and follow the plan for treatment according to MDS, IDT, DON, PT, and NP/MD. The risk of if the care plan is not revised to address the hand contracture; the resident could lose total control and continue to get worse if therapy is not being provided. In an interview with MDS RN on 02/25/2026 at 12:41pm she stated care plans are updated through IDT process which includes initials, annuals, and acute care. MDS RN stated she is aware Resident #69 has multiple sclerosis and it could affect his hands. She also stated if Resident #69 was admitted with contractures, it would have been addressed on the MDS assessment. The expectation for assessments and care plans is communication from nursing by a communication form, CNA report, verbal, or communication meetings. If the information is not communicated, she cannot assess any changes to ensure the care plan is updated. In addressing the concern for Resident #69, the contracture should have been incorporated into the care plan, as failure to do so could place him at risk for reduced mobility and increased need for assistance with eating. In an interview with ADMN on 02/25/2026 at 1:01pm she stated the expectation for revising care plans (continued on next page)		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on interviews, and record review, the facility failed to ensure the residents environment remained as free of accident hazards as was possible and ensure each resident received adequate supervision for 1 (Residents #71) of five residents reviewed for accidents and hazards. The facility failed to ensure that Resident #71's face was not pressed against the nightstand while she was getting incontinent care. This failure could place residents at risk of injury. Findings included: Record review of a face sheet dated 2/25/2026 indicated Resident #71 was a [AGE] year-old female who admitted on [DATE] with diagnoses including Type 2 Diabetes, Hypermetropia, farsighted, Age-Related Nuclear Cataract, Bilateral (A Major cause of blindness), Dementia, Major depressive disorder, Anxiety disorder, Heart Failure, and Edema (Swelling caused by excess fluid trapped in the body's tissues). Record review of the comprehensive care plan dated 01/07/2026 indicated Resident #71 was at risk to falls related to impaired cognition, confusion, gait/balance problems, incontinence, functional quadriplegia (complete immobility). The intervention for Resident #71 included anticipate and meet the resident's needs and be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The comprehensive care plan indicated Resident #71 was incontinent of bowel and bladder. The interventions included apply barrier cream after every incontinent episode, check resident every two hours and assist with toileting as needed. Check resident every two hours and assist with toileting as needed. Record review of an admission MDS dated [DATE] indicated Resident #71 had a BIMS score 07 which indicated she had severe cognitive impairment. Section GG Functional Status of the MDS indicated Resident #71 required a wheelchair and was dependent (Helper does all of the effort. Resident does none of the effort to complete the activity). Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with toileting hygiene, lower body dressing, putting on/taking off footwear, sit to stand, chair/bed to chair transfer and tub/shower transfer. The MDS in Section H Bladder and Bowel indicated Resident #71 was always incontinent of bowel and bladder. In an interview on 02/24/2026 at 9:39AM with Resident #71, she stated there was an incident last month in which she was getting incontinent care and her face was pressed up against the nightstand when CNA-JK turned her over. She stated she did not think CNA JK did it on purpose but reported that it caused discomfort to her right side of her jaw. In an interview on 02/25/2026 at 2:59PM with CNA JK, she stated she was familiar with Resident #71 because she had worked with her in the past. She stated about a month ago, she and another CNA were doing incontinent care with Resident #71 and they turned her carefully and her face was placed on the nightstand. She stated the resident did not complain of any pain. She stated she never noticed that her face was swollen. She stated after incontinent care was finished, they carefully turned the resident back over. She stated no one ever informed her that the resident complained that she was hurt or that she was in discomfort. She stated the resident was a two person assist and another CNA was assisting her that day. She stated she worked with the resident prior to the incident and she does not recall the resident complaining of pain to her jaw just pain to her legs. She stated an in-service was done after the incident with the former DON to educate her of the situation due to the residents face being place on the dresser during incontinent care. In an interview on 02/26/2026 at 9:47AM with Previous DON - She stated she was employed at facility from November 2025- February 03, 2026. She stated Resident #71 informed her that she did not want CNA JK working with her anymore due to her not listening and stated she was not doing what she wanted her to do so she (continued on next page)		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents who needed respiratory care were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for one of three (Resident #6) residents reviewed for respiratory care. The facility failed to ensure Resident #6's oxygen was administered at the prescribed setting. These deficient practices could place residents who receive respiratory care at an increased risk of developing respiratory complications and a decreased quality of care. The findings included: Record review of Resident #6's face sheet dated 02/25/26 revealed a [AGE] year-old admitted to the facility on [DATE] and initially admitted on [DATE]. Resident #6's diagnoses included progressive supranuclear ophthalmoplegia (a rare neurological disorder characterized by the gradual loss of voluntary eye movement), chronic respiratory failure with hypoxia (a long-term condition where lungs cannot supply enough oxygen to the blood, leading to persistently low oxygen levels), Alzheimer's disease, bipolar disorder (a mental illness characterized by mood swings and depressive episodes) and shortness of breath (SOB). Record review of Resident #6's quarterly MDS dated [DATE] revealed a BIMS score of 8 out of 15 indicating moderate cognitive impairment. Section O of the MDS revealed she was receiving oxygen therapy treatments. Record review of Resident #6's order summary report revealed a physician's order for oxygen 3L/m via nasal cannula every shift r/t chronic respiratory failure with hypoxia, date ordered 02/24/26. Further review revealed a Hospice Services, date ordered 03/20/25. Record review of Resident #6's undated care plan revealed: focus - Resident #6 has Oxygen Therapy - date initiated 09/16/25. Goal - Resident #6 will have no s/sx of poor oxygen absorption. Interventions included - give medications as ordered by physician; oxygen as ordered per nasal cannula. Record review of Resident #6's Physician Progress Notes effective date 02/23/26 included pulmonary function testing results from 12/02/25 read in part: .Clinical Significance: Confirms severe restrictive lung disease. Patient reports shortness of breath with history of 2 years smoking. Findings support continued supplemental oxygen for comfort, respiratory status monitoring, and optimization of comfort measures for dyspnea management given hospice status. Record review of Resident #6's Oxygen Saturation Summary revealed on 02/24/26 at 12:30 AM, Resident #6's oxygen saturation rate was 98%, with oxygen via nasal cannula. Observation and interview on 02/24/26 at 10:00AM revealed Resident #6 was receiving oxygen via nasal cannula and the oxygen concentrator setting was 4L/min. Resident #6 stated the oxygen was to help her breathing. Observation and interview on 2/25/26 at 9:43 AM revealed Resident #6 did not have the nasal cannula on her face. The nasal cannula was draped over the bedside table out of reach for Resident #6. The oxygen concentrator was set at 4L/m. Resident #6 stated that sometimes she did not like the nasal cannula on because it hurt the back of her ears and she did not know why it was on the table. Resident #6 was not in any respiratory distress. Observation and interview on 02/25/26 at 10:40 AM revealed LVN G replaced the nasal cannula on Resident #6 and stated sometimes Resident #6 takes off the nasal cannula d/t pain behind the ears. LVN G stated he would get something to help cushion the back of the ears. LVN G stated the oxygen setting was supposed to be at 3L/m and then reduced the oxygen from 4L/m to 3L/m. When asked if he checked the oxygen setting, LVN G stated he replaced the humidifier early in the morning and checked her O2 saturation rate which was in the 90's. When asked why the oxygen concentrator was set at 4L/m, LVN G stated he would check her saturation rates. In an interview on 2/25/26 at 11:00 AM, LVN G stated Resident #6's oxygen saturation rate was currently 97 to 98%. LVN G stated he was responsible for ensuring the oxygen was set correctly as per physician orders. LVN G stated the reason Resident #6 was receiving oxygen was d/t her diagnoses of chronic respiratory failure and shortness of breath and that the order was for continuous oxygen. LVN G stated the goal for oxygen saturation is to be no less than 92% and 93% or greater would be more than ideal. LVN G stated the (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455725	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Oakmont Healthcare and Rehabilitation of Humble		STREET ADDRESS, CITY, STATE, ZIP CODE 8450 Will Clayton Pkwy Humble, TX 77338	
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	risk of not having enough oxygen delivered would be shortness of breath and the resident may pass out. LVN G stated Hospice services were in Resident #6's room earlier in the day and maybe took the nasal cannula off, forgetting to replace it after providing care to Resident #6. In an interview on 2/26/26 at 8:30 AM the Interim DON stated it was the nurse's responsibility to ensure oxygen was set correctly by physician orders and that she expected the nurses to monitor settings every shift to ensure residents did not have breathing issues because they are on oxygen for a reason and orders should be followed. The Interim DON stated the risk to a resident was potential shortness of breath. The Interim DON stated Hospice services was with Resident #6 on 2/24/26 and on 2/25/26 and may have set the oxygen to 4L/m. Record review of the facility's undated policy for Oxygen Administration read in part: .Oxygen therapy includes the administration of oxygen (O2) in liters/minute (l/min) by cannula or face mask to treat hypoxemic conditions caused by pulmonary or cardiac diseases. O2 therapy is also prescribed to ensure oxygenation of all body organs and systems. The amount of oxygen by percent of concentration or L/min, and the method of administration, is ordered by the physician. The administration, monitoring of responses, and safety precautions associated with it are performed by the nurse.		