STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465009	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harrison Pointe Healthcare and Rehabilitation	3430 Harrison Boulevard Ogden, UT 84403

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility did not store, prepare and distribute food in accordance with professional standards for food service safety. Specifically, the dish machine washing temperature was not meeting the manufacturer requirements. Findings included: On 3/1/26 at 8:32 AM, an interview was conducted with [NAME] 1. [NAME] 1 stated the dish machine was a low temperature machine. The dish machine had a label which revealed that the wash temperature should reach 120 degrees Fahrenheit minimum and the rinse temperature should reach 120 degrees Fahrenheit minimum. On 3/4/26 at 9:00 AM, the following observations were made of the dish machine: [Note: All temperatures (temps) were in degrees Fahrenheit.]a. At 9:00 AM, the wash temp was 110 and the rinse temp was 120. There were plates, bases, and trays observed to be washed in the dish machine cycle. The dishes were observed to be put away with the clean dishes at 9:13 AM, by the Dietary Manager (DM). b. At 9:14 AM, the wash temp was 105 and the rinse temp was 117. There were trays, plates, and bases observed to be washed in the dish machine cycle. At 9:20 AM, the DM put away the trays with clean trays. c. At 9:15 AM, the wash temp was 105 and the rinse temp was 119. There were plates, bases, and trays observed to be washed in the dish machine. At 9:21 AM, all plates, bases, and trays were put away with the clean dishes. d. At 9:21 AM, the wash temp was between 105 and 110. The rinse temperature was at 120. There were trays and domes observed to be washed in the dish machine. The trays and domes were put away with the clean dishes. e. At 9:28 AM, an observation of the dish machine temperatures were observed with [NAME] 1. [NAME] 1 verified the washing temperature was 110 and the rinse was 120. [NAME] 1 checked the sanitizer and it was 100 parts per million. [NAME] 1 stated the dish machine needed to run a few times for it to reach 120 for the washing cycle. f. At 9:30 AM, the wash temp was observed to be 118 and the rinse was between 122 and 124. [NAME] 1 verified the temps. [NAME] 1 stated to the DM the washing temperature was not high enough. g. At 9:34 AM, an observation was made with the DM using the digital thermometer in the dish machine water. The digital thermometer was 114.6 for the wash and rinse was 123. The dish machine thermometer had the same temperature reading. The dish machine temperature log was reviewed and the DM signed that the washing temperature was 120 and rinse was 120 on 3/4/26, for breakfast, despite the above observations. On 3/4/26 at 9:37 AM, an interview was conducted with the DM. The DM stated he checked the dish machine about 8:00 AM, and the temperatures were at 120 for the wash and the rinse. The DM stated sometimes the dish machine thermometer did not work so he used the digital thermometer which had the same reading. The DM stated he was going to get the Maintenance Director to look at the dish machine. On 3/4/26 at approximately 10:30 AM, an interview was conducted with the Director of Nursing and the Administrator. The Administrator stated the facility had a contractor working on the washing machines which was probably why the dish machine temperatures were lower.

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

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe and sanitary environment. Specifically, for 3 out of 29 sampled residents, a resident with a surgical wound did not have Enhanced Barrier Precautions (EBP) posted or in place; appropriate hand hygiene and glove changes were not performed between dirty and clean tasks or resident contact; and during a dressing change a clean field was not maintained and bandages were contaminated. Resident identifiers: 9, 32, and 59.Findings included: 1. Resident 59 was admitted to the facility on [DATE] with diagnoses which included displaced trimalleolar fracture of right lower leg and syncope and collapse. Review of resident 59's medical record was completed on 3/1/26 through 3/4/26. On 2/19/26, a physician's order documented, ENHANCED BARRIER PRECAUTIONS: PPE [person protection equipment] required for high resident contact care activities. Indication: Right ankle external fixator. every shift for Surgical wound. On 3/1/26 at 3:03 PM, an observation of resident 59's room was conducted regarding the implementation of EBP. The observation revealed that there was no EBP notification or signage posted outside of the room to alert staff of required precautions. Furthermore, there was no PPE, such as gowns or gloves, available for use either inside or immediately outside of the resident's room. On 3/3/26 at 8:33 AM, during wound care treatment for resident 59, the following was observed: a. At 8:33 AM, Registered Nurse (RN) 3 was observed entering resident 59's room. She discussed the necessity of wound care with the resident and asked if she could perform the treatment. b. At 8:37 AM, RN 3 was observed placing a chuck (disposable underpad) directly on the floor to serve as the surface for wound care supplies. c. At 8:39 AM, RN 3 was observed donning gloves and removing the soiled bandage from the left (L) calf. The procedure was completed without donning any required EBP or PPE beyond gloves. d. At 8:40 AM, RN 3 was observed to clean the site on L calf and apply a clean bandage using the same gloves used to remove the soiled dressing. It should be noted that no hand hygiene was performed during the transition from dirty to clean tasks. e. At 8:42 AM, RN 3 was observed unwrapping an ACE bandage from the right (R) leg while still wearing the contaminated gloves from the treatment on the L calf. f. At 8:45 AM, RN 3 was observed removing her gloves and donned a fresh pair. RN 3 removed the gauze wrapping and ACE bandage over a R dorsal foot blister. g. At 8:47 AM, RN 3 was observed obtaining clean gauze, sprayed it with wound cleaner, and patted the blister on R foot. RN 3 continued to spray clean gauze and cleaned pin sites on the lower half of the R ankle external fixation surgical device. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	h. At 8:48 AM, RN 3 was observed removing her gloves and proceeded to open gauze packets, remove the gauze, and cut the gauze pad. This was noted to be performed with her bare hands. i. At 8:51 AM, RN 3 was observed donning a new pair of gloves and proceeded to remove the remaining gauze on the upper half of the R ankle external fixation surgical device. j. At 8:54 AM, RN 3 was observed cleaning the pins of the upper half of the R ankle external fixation surgical device with wound spray and gauze. k. At 8:55 AM, The Maintenance Director was observed entering the room and stepping over the wound supply field. l. At 8:55 AM, an observation was made of RN 3 at which time she sprayed a piece of the cut gauze with wound spray then wrapped it around each one of the pins. It should be noted that no hand hygiene was performed during the transition from dirty to clean tasks. m. At 8:57 AM, an observation was made of RN 3 applying the clean gauze wrap around the lower R leg. n. At 9:00 AM, RN 3 was observed reapplying the ACE wrap that had been previously removed. RN 3 stated to resident 59 that the ACE bandage was changed every other day. o. At 9:03 AM, RN 3 was observed gathering used supplies and tossed them into the trash can inside the resident's room and left the room. It should be noted, the contaminated supplies were left in the room upon her exit. On 3/4/26 at 8:30 AM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that when a resident was on EBP, she clarified the specific precautions with the nurse. CNA 1 stated that she would don PPE when providing direct care or when she expected to be in close proximity to the resident. Furthermore, CNA 1 stated that according to her understanding of facility practice, it was not necessary to don PPE when entering the resident's room for non-care tasks, such as delivering meal trays. On 3/3/26 at 9:15 AM, an interview was conducted with RN 3. RN 3 stated that she recently began working at the facility and was currently still in training, noting that she was not yet fully familiar with the facility's specific EBP policies. During the interview, RN 3 identified that residents exhibiting coughs, or those with bodily fluids or wounds, should have orders in place for EBP. RN 3 further stated that residents admitted from the hospital with indwelling devices would also require an order for precautions and EBP. Regarding her clinical practice, RN 3 stated that she dons PPE upon entering a resident's room for pretty much any care involving direct contact. On 3/4/26 at 8:42 AM, a follow-up interview was conducted with RN 3. RN 3 initially stated that an external fixation device was not an open wound. RN 3 explained this assessment was based on her extensive experience in wound care, which led her to view the sites as closed. However, upon further discussion, RN 3 corrected her statement, acknowledging that because the pins create a direct opening to the body, the site was technically an open wound. On 3/4/26 at 9:17 AM, an interview was conducted with RN 2. RN 2 stated that residents with indwelling medical devices (tubing entering the body) or open wounds require EBP. RN 2 indicated (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that PPE should be donned prior to entering the room, specifically when working near the site of entry or during close contact with the resident. RN 2 stated that an external fixation device was considered a closed device. RN 2 confirmed that PPE must be worn when performing bandage changes for such devices to maintain proper infection control. On 3/4/26 at 10:04 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that residents requiring EBP include those with feeding tubes, Multi-Drug Resistant Organisms , chronic wounds, intravenous treatment, catheters, or any indwelling devices. The DON stated these requirements were documented in the physician's orders and the resident's care plan. The DON stated that staff should wear PPE when providing close proximal care or performing any direct resident care. The DON stated she would classify an external fixation device as a surgical wound but noted she was consulting a reference for further clarification. During the interview, the DON confirmed that resident 59, did in fact have an order in place for EBP. The DON stated that facility policy requires clean technique and that gloves must be changed, with hand hygiene performed, between dirty and clean procedures during the same treatment. 2. On 3/3/26 at 6:30 AM, during morning medication pass the following was observed: a. At 6:31 AM, Licensed Practical Nurse (LPN) 1 was observed to touch her computer keyboard, the computer mouse, the top of the medication cart, and the medication cart keys. LPN 1 was then observed to begin removing medication packs for resident 9 from the medication cart and place them into a medication cup. b. At 6:33 AM, LPN 1 was observed to hand the medication cup to resident 9 and resident 9 took his medication. It should be noted that LPN 1 had not performed hand hygiene before or after administering resident 9 their medication. c. At 6:47 AM, LPN 1 was observed to remove the glucometer from the medication cart. LPN 1 was observed to pick up gloves and the glucometer and enter resident 32's room. d. At 6:49 AM, LPN 1 was observed to don gloves without performing hand hygiene prior to donning the gloves and performed a blood sugar check with the glucometer on resident 32. LPN 1 doffed the gloves prior to exiting the room and did not perform hand hygiene. e. At 6:56 AM, LPN 1 was observed to touch her computer keyboard, the computer mouse, the top of the medication cart, and the medication cart keys. LPN 1 was observed to begin removing medication packs for resident 32 from the medication cart and place them into a medication cup. f. At 7:04 AM, LPN 1 was observed to hand the medication cup to resident 32. Resident 32 requested additional pain medication and LPN 1 was observed to take the medication cup back from the resident, pour the cup of Miralax down the sink that the resident refused and exited the room. It should be noted that LPN 1 had not performed hand hygiene before preparing resident 32's medication or after taking the medication cup back from resident 32. g. At 7:08 AM, LPN 1 was observed to touch her computer keyboard, the computer mouse, the top of the medication cart, the narcotic binder, and the medication cart keys. LPN 1 was observed to place medication into resident 32's medication cup. LPN 1 was observed to enter resident 32's room and hand resident 32 her medication cup. It should be noted that LPN 1 did not perform hand hygiene prior to administering resident 32 her medication. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/3/26 at 7:36 AM, an interview was conducted with LPN 1. LPN 1 stated that she should perform hand hygiene before and after preparing medications for residents. LPN 1 stated that there usually was hand sanitizer on the cart, but she was unable to locate the hand sanitizer. On 3/3/26 at 8:50 AM, an interview was conducted with the DON. The DON stated that she expected nursing staff to wash their hands when performing medication pass whenever they thought about it and in between patients. The DON stated that there should be hand sanitizer on the medication cart and there was hand sanitizer on the walls in the hallways for nursing staff to use.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. Specifically, for 1 out of 29 sampled residents, a resident that did not have exit seeking behavior had a wander guard put on. Resident identifier: 32. Findings included:Resident 32 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, unspecified dementia, unspecified severity, without behavior disturbance, psychotic disturbance, mood disturbance, and anxiety, metabolic encephalopathy, and mild cognitive impairment.On 11/28/25, an Elopement/Wandering Assessment was completed. Resident 32 was documented as a low wander risk, resident 32 had no elopement history, and was alert and oriented.On 12/19/25 at 12:43 PM, a Nurse Practitioner / Physician Assistant Progress Note documented . She has no hallucinations/delusions, no violent behavior, no verbal threating [sic] or screaming behavior and she does not try to wander out of the facility.On 1/26/26 at 2:53 PM, a Nursing Note documented Pt [patient] had a fall in room in early AM had hit left side head on footboard, pt has small bruise right side temple area . Pt is on abx [antibiotic] for UTI [urinary tract infection] and has baseline confusion. Wander guard put on to prevent exiting faculty [sic] due to wandering around, will often forgether [sic] walker. Wander guard to left ankle. Husband and MD [Medical Director] aware of fall and ankle guard. Neuro [neurologicals] check normal limits.On 1/29/26 at 4:08 PM, a Nursing Note documented . Pt has confusion at baseline but has had increased confusion being treated for UTi has foley cath [catheter] .On 1/31/26 at 1:52 PM, a Daily Skilled Note documented . resident asked to have the wander guard removed today. Reminded her that she needed it on because she was still a little confused due to the UTI. Informed her it was to keep her safe. She agreed that was a good idea and stated it was okay then to leave it on.It should be noted that resident 32 completed the antibiotic for the UTI on 2/1/26.A care plan focus initiated on 2/1/26 documented Elopement risk/wanderer r/t [related to] impaired cognition, wandering. The interventions included, document wandering behavior and attempted diversional interventions, monitor wander guard placement, and provide structured activities: toileting, walking, reorientation strategies.It should be noted that resident 32 had no documented wandering behavior.On 2/23/26 at 2:01 PM, a Minimum Data Set (MDS) Note documented . She does not wander and does not reject cares.On 2/27/26, a quarterly MDS assessment documented that resident 32 had a Brief Interview for Mental Status (BIMS) score of 10. A BIMS score of 8 to 12 would indicate moderate cognitive impairment.On 3/1/26, an Elopement/Wandering Assessment was completed. Resident 32 was documented as a low wander risk, resident 32 had no elopement history, and had intermittent confusion. On 3/2/26 at 12:19 PM, an interview was conducted with resident 32. Resident 32 was asked about the wander guard bracelet that was observed on her left ankle. Resident 32 appeared excited and asked if I was going to take the wander guard off. The nurse walked in during the interview to get resident 32's blood glucose reading and stated to resident 32 that the wander guard had to stay on.On 3/2/26 at 12:20 PM, an interview was conducted with Licensed Practical Nurse (LPN) 2. LPN 2 stated that resident 32's confusion would go up and down. LPN 2 stated when resident 32 had the UTI, resident 32 walked by the nurses station, and out the front door. LPN 2 stated that resident 32 did not particularly have a history of wandering up until that one night. LPN 2 stated that resident 32 had more confusion with the most recent admission.On 3/3/26 at 8:32 AM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated the staff did not do much for resident 32 because she was required only supervision with cares. CNA 1 stated that staff did catheter cares for resident 32. CNA 1 stated that resident 32 was ambulatory and ambulated pretty well. CNA 1 stated that resident 32 did not exit seek. CNA 1 stated that resident 32 may have (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had exit seeking behaviors before she started working at the facility but she was not aware of any. CNA 1 stated that resident 32 did get confused sometimes. CNA 1 stated that yesterday resident 32 was more confused but not exit seeking. On 3/4/26 at 7:48 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 32 would get confused and she was a higher risk. The DON stated the wander guard was on just in case and resident 32 had the potential to wander. The DON stated the facility would try to get the residents out to a different facility if they were a wander risk. The DON stated that resident 32 would wander up to the front doors.The facility policy Elopement / Unsafe Wandering was reviewed. PolicyIt is the policy of this facility to provide a safe environment, as free of accidents as possible, for all residents through appropriate assessment, interventions, and adequate supervision to prevent accidents related to unsafe wandering or elopement while maintaining the least restrictive manner for those at risk for elopement.Definitions:Wandering is the random or repetitive locomotion and can be either goal directed or non-goal directed/aimless.Procedure1. Residents with capabilities of ambulation and/or mobility in wheelchair will have an Elopement/Wandering Evaluation completed to determine risks for elopement and unsafe wandering on admission and with observed behaviors of wandering or attempts to elope.2. Residents with high risk factors will be identified as At Risk and will have an individualized care plan developed that includes measurable objectives and timeframes.a. Care plan interventions will consider the elements of the evaluation or behavior observations that identified the resident at risk.b. Interventions will address the individualized level of supervision needed to prevent elopement/unsafe wandering.3. Staff shall promptly report any resident who is trying to leave the premises or is suspected of being missing to the Charge Nurse or Supervisor to evaluate the need for further interventions.The policy had a revision/review date of 4.2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that the services provided met professional standards of quality. Specifically, for 2 out of 29 sampled residents, a resident's tube feeding did not have the formula bag labeled with the correct date and time of the formula preparation, or the nurse's initials who initiated the infusion. In addition, a resident's tube feeding was not labeled with all of the required information. Resident identifiers: 4 and 44. Findings included: 1. Resident 4 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis following a cerebral infarction, chronic obstructive pulmonary disease, protein-calorie malnutrition, and dysphagia. On 3/1/26 at 10:27 AM, an observation was made of resident 4's tube feeding formula. The formula infusing was Jevity 1.2. There was a written date of 3/1/26 at 0940 [9:40 AM]. Resident 4 and his family member were interviewed. Resident 4's family member stated resident 4 was receiving a Two calorie formula for weight gain and the tube feeding ran for 14 hours during the day. A physician's order dated 2/25/26, revealed Start at 0500 [5:00 AM] stop at 2000 [8:00 PM] Start feeding Run Two Cal [calorie] enteral feed at 90ml/hr. [milliliter per hour] x 14 hours tv [total volume] +1190 Water flushes 80ml/q2h [milliliter per every two hours] with a water flush of 65ml/hr. times 14 hours TV=910 AND at bedtime for Start at 0500 stop at 2000 Stop feeding 2000. On 3/1/26 at 3:31 PM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that she was aware that resident 4's tube feeding was 1.2 calorie instead of the Two cal, so she changed it to the Two cal. RN 1 stated she was not sure what time she changed the formula from Jevity 1.2 calorie to the Two cal formula. RN 1 observed the tube feeding formula infusing into resident 4. It was observed to be Two cal with the date of 3/1/25 at 0800 [8:00 AM] written on the formula container. RN 1 stated she must have changed it at 8:00 AM, after the surveyor was in the room. RN 1 stated she did not hang the Jevity 1.2 formula and it should have been started at 5:00 AM. It should be noted, the Jevity 1.2 was observed to be infusing on 3/1/26 at 10:27 AM, and the Two cal was not infusing at that time even though it was documented as started on 3/1/26 at 8:00 AM. On 3/3/26 at 12:48 PM, an interview was conducted with RN 2. RN 2 stated resident 4 needed his tube feeding infusing for 14 hours at 90 ml/hr. RN 2 observed the tube feeding and there was a date of 3/3/26 at 0500. There was no other written information on the tube feeding formula. 2. Resident 44 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, dysphagia, and protein calorie malnutrition. On 3/1/26 at 12:13 PM, an observation was made of resident 44's tube feeding formula. The tube feeding formula was labeled 14 a 3/1. The pump was set at a continuous rate of 45 ml/hr. On 3/3/26 at 6:52 AM, an observation was made of resident 44's tube feeding formula. The tube feeding formula was labeled 14 A 3/3/26 0445 [4:45 AM]. A physician's order dated 2/13/26, documented Enteral Feed Order every shift Jevity 1.2 45ml/hr, x 24 hrs [hours] Water flush 150ml Q4 hrs [milliliter every four hours]. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/3/26 at 7:46 AM, an interview was conducted with RN 2. RN 2 stated that she would change and throw out the old feeding stuff daily. RN 2 stated that she would label the tube feeding formula with the date, time, room number, patient's name, signature of the nurse, name of formula, and dose of the formula. RN 2 stated that on the water bag she would put the date, time, patient 's name, nurse signature, and the rate of the water to be given. On 3/4/26 at 7:51 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the tube feeding formula was already labeled. The DON stated that she would expect the nurse to write on the tube feeding formula the date, time, and room number. The facility policy Infection Control Policy / Procedure was reviewed. Section: Resident Care Subject: Tube Feeding – Nasogastric or Gastrostomy . PROCEDURES: Pre-mixed feedings are preferable, the following procedure will be followed with all enteral (tube) feedings. 2. Prepare feeding using clean technique according to the physician's order. A. Label the feeding bag with the resident's name, room, date and time started, kind and strength of feeding. B. Take to the bedside. 6. Feeding container is to be labeled with time started with each new feeding. The facility policy was revised on 06/2007. Review of the Lippincott Nursing Procedures documented under Enteral Gastric, Duodenal, and Jejunal Tube Feeding for implementation to Make sure that the enteral formula container is labeled with the patient's identifiers; formula name (and strength if diluted); date and time of formula preparation; date and time the formula was hung; administration route, rate, and duration (if cycled or intermittent); initials of who prepared, hung and checked the enteral formula against the order; expiration date and time; dosing weight (if appropriate); and notation ENTERAL USE ONLY–NOT FOR IV USE. Wolters Kluwer. Lippincott Nursing Procedure. Ninth Edition. Philadelphia, PA. (2023), pp 296.

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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 observation, interview, and record review, the facility did not ensure that a resident who needed respiratory care, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Specifically, for 1 out of 29 sampled residents, a resident with a bilevel positive airway pressure (BiPAP) machine was unable to use the machine due to missing parts. Resident identifier: 5.Findings included: Resident 5 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, chronic obstructive pulmonary disease, asthma, and obstructive sleep apnea.On 3/1/26 at 9:22 AM, an interview was conducted with resident 5. Resident 5 was observed with an oxygen concentrator. Resident 5 stated that he had been using oxygen for about a month. Resident 5 stated he had not used his BiPAP machine since he admitted to the facility. A BiPAP machine was observed on resident 5's bedside nightstand. Resident 5 stated the BiPAP machine was missing a special adapter to hook up the oxygen. Resident 5 stated they would prefer he used the BiPAP while sleeping and not the oxygen. Resident 5 stated he ordered the adapter from the Veterans Affairs (VA) but he had not seen it.Resident 5's medical record was reviewed. There were no progress notes, physician orders, or a care plan that documented the BiPAP machine.On 1/6/26, an Inventory Of Personal Effects did not include a BiPAP machine.On 3/3/26 at 10:50 AM, an interview was conducted with Registered Nurse (RN) 3 and Licensed Practical Nurse (LPN) 1. LPN 1 stated if a resident was admitted with or needed a BiPAP machine she would make sure there was a physician order and if not she would get the physician order from the provider. LPN 1 stated that she would make sure the resident had a diagnosis for the BiPAP machine. RN 3 stated that she would look at the BiPAP machine and make sure it was safe, the set up was correct, the cords were good, and the BiPAP machine was clean. RN 3 stated that staff would need to wash the BiPAP machine mask daily. RN 3 stated that resident 5 had a nebulizer but she was not aware of a BiPAP machine.On 3/3/26 at 10:57 AM, an observation was conducted of resident 5's room with RN 3. RN 3 observed the BiPAP machine on resident 5's bedside nightstand next to the nebulizer machine. Resident 5 stated that he needed the adapter for the air. Resident 5 stated he brought the BiPAP machine with him on admission to the facility. Resident 5 stated he had ordered the adapter twice from the VA to be delivered to the facility. Resident 5 stated that he really really needed the adapter. On 3/3/26 at 11:27 AM, an interview was conducted with the Assistant Director of Nursing (ADON) and the Regional Nurse Consultant (RNC). The ADON stated that resident 5 admitted from home without orders for the BiPAP machine. The ADON stated they did not know resident 5 had a BiPAP machine. The ADON stated that resident 5 wanted to start using the BiPAP machine. The ADON stated they were going to get resident 5 set up at the sleep center to get the adapter for the BiPAP machine. The ADON stated that resident 5 had been working with the VA on his own to get the adapter. The RNC stated that if the resident had a diagnosis they would usually try to set the resident up with something.