

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/02/2025
NAME OF PROVIDER OR SUPPLIER Valley Vista Nursing and Transitional Care LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6120 N. Vineland Ave North Hollywood, CA 91606	

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (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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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from unnecessary psychotropic medication (medications that affect the mind, emotions, and behavior) and the use of chemical restraints (any drug that is used for discipline or staff convenience and not required to treat medical symptoms) for one of three sampled resident (Residents 1) by failing to: 1. Provide ongoing re-evaluation of the need for psychotropic medication by failing to ensure PRN (given as needed or requested) Haloperidol (a medication used to treat mental health conditions to reduce hallucinations, delusions, and uncontrolled movements) was ordered with an end date (time at which a medication will no longer be dispensed and will be required to be re-prescribed). 2. Monitor Resident 1 for measurable behaviors related to schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). These deficient practices had the potential to result in the administration of unnecessary psychotropic medication and placed Resident 1 at risk for decline in physical functioning and injury. Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted Resident 1 on 7/11/2025 and readmitted on [DATE], with diagnoses including chronic obstructive pulmonary disease (COPD- a progressive lung disease that blocks airflow, making breathing difficult), schizoaffective disorder, and unspecified dementia (a progressive state of decline in mental abilities). During a review of Resident 1's History and Physical (H&P), dated 11/22/2025, the H&P indicated Resident 1 was able to make needs known but did not have the capacity to make medical decisions. During a review of Resident 1's Minimum Data Set (MDS-resident assessment tool), dated 11/13/2025, the MDS indicated Resident 1 had severely impaired cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS indicated Resident 1 required maximal assistance (helper does more than half the effort) from the facility staff with toileting hygiene, showers, and lower body dressing. During a concurrent interview and record review on 12/2/2025 at 12:29 p.m. with Registered Nurse (RN) 1, Resident 1's Order Summary Report was reviewed. The Order Summary Reported indicated the following orders:-11/20/2025: Haloperidol oral tablet one milligram (mg-unit of measurement). Give 1 tablet via gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) every 12 hours as needed for schizoaffective disorder. RN 1 stated physician orders for PRN psychotropic medications such as Haloperidol need to have an end date and should be prescribed for 14 days. RN 1 stated residents need to be reevaluated by the physician to determine if the medication is indicated. RN 1 stated residents who receive psychotropic medications should be monitored for specific behavioral manifestations such as mood changes. RN 1 stated the facility failed to place an end date for Resident 1's Haloperidol order. RN 1 stated the facility failed to monitor Resident 1's behavioral manifestations related to schizoaffective disorder. RN 1 stated without monitoring behavioral manifestations a reevaluation by the physician, Resident 1 had the potential to receive a medication she (Resident 1) did not benefit from. RN 1 stated Resident 1 had the potential to experience drowsiness and medication side effects. RN 1 stated these failures had the potential for Resident 1 to receive unnecessary medication that could be considered a chemical restraint as well, negatively affecting Resident 1's well-being. During a review of the facility-provided policy and procedure (P&P) titled, Antipsychotic Medication Use, last reviewed on 7/3/2025, the P&P indicated, Residents will not receive medications that are not clinically indicated to treat a specific condition. Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review. 1. Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. 2. The attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risk to the resident and others. 16. PRN orders for antipsychotic medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication and documented the rationale for continued use. The duration of the PRN order will be indicated in the order.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the comprehensive care plan (a plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs) was reviewed and revised for one of three sampled residents (Resident 1) by failing to update Resident 1's care plan to reflect Resident 1's indwelling catheter (a flexible plastic tube inserted into the bladder that remains there to provide continuous urinary drainage). This failure had the potential to delay care and negatively affect Resident 1's well-being. Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted Resident 1 on 7/11/2025 and readmitted on [DATE], with diagnoses including chronic obstructive pulmonary disease (COPD- a progressive lung disease that blocks airflow, making breathing difficult), acute respiratory failure (a severe condition where lungs can't adequately oxygenate blood or remove carbon dioxide, requiring emergency care), and unspecified dementia (a progressive state of decline in mental abilities). During a review of Resident 1's History and Physical (H&P), dated 11/22/2025, the H&P indicated Resident 1 was able to make needs known but did not have the capacity to make medical decisions. During a review of Resident 1's Minimum Data Set (MDS-resident assessment tool), dated 11/13/2025, the MDS indicated Resident 1 had severely impaired cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS indicated Resident 1 required maximal assistance (helper does more than half the effort) from the facility staff with toileting hygiene, showers, and lower body dressing. During a review of Resident 1's Clinical Admission form, dated 11/20/2025, the form indicated the facility admitted Resident 1 on 11/20/2025 with a new indwelling catheter. During a concurrent interview and record review on 12/2/2025 at 12:29 p.m. with Registered Nurse (RN) 1, Resident 1's Care Plan was reviewed. RN 1 stated the facility failed to update Resident 1's Care Plan to address Resident 1's indwelling catheter when the facility readmitted Resident 1 on 11/20/2025. RN 1 stated Resident 1's Care Plan should have been updated to reflect goals and interventions necessary for Resident 1's indwelling catheter care. RN 1 stated without developing a Care Plan to address Resident 1's goals, the facility staff would not be able to monitor if Resident 1 was benefiting from the indwelling catheter. RN 1 stated Resident 1's Care Plan was not resident-centered, and had the potential to delay care for Resident 1. During a review of the facility-provided policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, last reviewed on 7/3/2025, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. e. reflects currently recognized standards of practice for problem areas and conditions. 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; . c. when the resident has been readmitted to the facility from a hospital stay.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice to meet the resident's physical, mental, and psychosocial (relating to the interrelation of social factors and individual thoughts and behavior) needs for one of three sampled residents (Resident 1) by failing to assess Resident 1's blood glucose (body's main energy source, regulated by the hormone insulin) level during a change in Resident 1's condition (a significant alteration in a resident's physical or mental state) on 11/15/2025. This deficient practice had the potential to place Resident 1 at risk for delayed care and negatively affect Resident 1's well-being. Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted Resident 1 on 7/11/2025 and readmitted on [DATE], with diagnoses including chronic obstructive pulmonary disease (COPD- a progressive lung disease that blocks airflow, making breathing difficult), acute respiratory failure (a severe condition where lungs can't adequately oxygenate blood or remove carbon dioxide, requiring emergency care), and unspecified dementia (a progressive state of decline in mental abilities). During a review of Resident 1's History and Physical (H&P - a comprehensive assessment of a resident's medical condition), dated 11/22/2025, the H&P indicated Resident 1 was able to make needs known but did not have the capacity to make medical decisions. During a review of Resident 1's Minimum Data Set (MDS-resident assessment tool), dated 11/13/2025, the MDS indicated Resident 1 had severely impaired cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS indicated Resident 1 required maximal assistance (helper does more than half the effort) from the facility staff with toileting hygiene, showers, and lower body dressing. During a review of Resident 1's Care Plan, initiated on 11/15/2025, the Care Plan indicated Resident 1 had an impaired gas exchange related to ineffective airway clearance. During a concurrent interview and record review on 12/2/2025 at 12:29 p.m. with Registered Nurse (RN) 1, Resident 1's Change of Condition (COC -major decline or improvement in a resident's status that will not resolve without intervention) form, dated 1/21/15025, timed at 6:50 a.m. as reviewed. The COC form indicated on 11/15/2025, at approximately 6:50 a.m., Resident 1 had abnormal vital signs as follows: blood pressure (the force of blood pushing against artery walls, measured as two numbers [systolic over diastolic], indicating pressure during heartbeats and rest) of 95/61 millimeters of mercury [mmHg-unit of measurement], heart rate of 123 beats per minute, respiratory rate of 23, oxygen saturation (the percentage of oxygen-carrying hemoglobin in the blood, with a normal level of 95-100 percent [%-unit of measurement]) of 70% and temperature of 100.2 Fahrenheit (F-unit of measurement). The COC form indicated the most recent blood glucose level for Resident 1 was 147 milligrams per deciliter (mg/dL-unit of measurement) dated from 11/8/2025. RN 1 stated the facility staff failed to obtain Resident 1's blood glucose levels on 11/15/2025 during Resident 1's change in condition. RN 1 stated when residents are experiencing change in condition, residents' blood glucose level needs to be assessed to rule out blood glucose related complications. RN 1 stated failure to assess blood glucose levels had the potential to delay care for Resident 1. During a review of the facility-provided policy and procedure (P&P) titled, Change in a Resident's Condition or Status, last reviewed on 7/3/2025, the P&P indicated, A 'significant change' of condition is a major decline or improvement in the resident's status that: a. will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not 'self-limiting'); b. impacts more than one area of the resident's health status. 3. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>(continued on next page)</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents with an indwelling catheter (a flexible plastic tube inserted into the bladder that remains there to provide continuous urinary drainage) receive proper care and services for one of three sampled residents (Resident 1), by failing to ensure Resident 1 received indwelling catheter care and monitoring. This deficient practice had the potential to place Resident 1 at risk for urinary tract infection (UTI- an infection in the bladder/urinary tract) and negatively affect Resident 1's well-being. Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted Resident 1 on 7/11/2025 and readmitted on [DATE], with diagnoses including chronic obstructive pulmonary disease (COPD- a progressive lung disease that blocks airflow, making breathing difficult), acute respiratory failure (a severe condition where lungs can't adequately oxygenate blood or remove carbon dioxide, requiring emergency care), and unspecified dementia (a progressive state of decline in mental abilities). During a review of Resident 1's History and Physical (H&P), dated 11/22/2025, the H&P indicated Resident 1 was able to make needs known but did not have the capacity to make medical decisions. During a review of Resident 1's Minimum Data Set (MDS-resident assessment tool), dated 11/13/2025, the MDS indicated Resident 1 had severely impaired cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS indicated Resident 1 required maximal assistance (helper does more than half the effort) from the facility staff with toileting hygiene, showers, and lower body dressing. During a review of Resident 1's Clinical Admission form, dated 11/20/2025, the form indicated the facility admitted Resident 1 on 11/20/2025 with a new indwelling catheter. During an observation on 12/2/2025 at 10:30 a.m. in Resident 1's room, Resident 1 was observed with an indwelling catheter secured at the side of the bed. During a concurrent interview and record review on 12/2/2025 at 10:37 with Licensed Vocation Nurse (LVN) 1, Resident 1's Order Summary Report was reviewed. The Order Summary Report did not indicate an order for an indwelling catheter placement, care, and monitoring. LVN 1 stated when Resident 1 was admitted to the facility on [DATE] with an indwelling catheter, the facility staff failed to place an order for the care and monitoring of the indwelling catheter. LVN 1 stated there was no record to indicate that Resident 1 received indwelling catheter care and monitoring. LVN 1 stated facility staff should have monitored Resident 1 for signs and symptoms of catheter complications, as well as monitor Resident 1's intake and output. LVN 1 stated Resident 1 had the potential to experience delays in care, UTI, and hematuria (blood in urine). During an interview on 12/2/2025 at 12:29 p.m. with Registered Nurse (RN) 1, RN 1 stated when residents are admitted to the facility with an indwelling catheter, the facility staff should place orders for the care of the indwelling catheter and monitoring for signs and symptoms of complications. RN 1 stated the facility staff failed to monitor Resident 1's indwelling catheter. RN 1 stated Resident 1's indwelling catheter could have potentially leaked or had a blockage and facility staff would not know due to lack of monitoring. RN 1 stated this failure had the potential to delay care for Resident 1 and place Resident 1 at risk for infection. During a review of the facility-provided policy and procedure (P&P) titled, Catheter care, Urinary, last reviewed on 7/3//2025, the P&P indicated, The purpose of the procedure is to prevent urinary catheter-associated complications, including urinary tract infections. Complications: 1. Observe the resident for complications associated with urinary catheters. Report unusual findings to the physician or supervisor immediately. Observe the resident's urine level for noticeable increase or decreases. If the level stays the same the same, or increases rapidly, report it to the physician or supervisor. Documentation: The following information should be recorded in the resident's medical record: 1. The date and time that catheter care was given.3. All assessment date obtained when giving catheter care.4. Character of urine such as color (straw-colored, dark, or red), clarity (cloudy, solid particles, or blood), and odor.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide respiratory care consistent with professional standards of practice for one of three residents (Resident 1), by failing to: 1. Ensure Resident 1's oxygen concentrator (a medical device that provides a concentrated source of oxygen) was turned on and the nasal cannula (a medical device that provides supplemental oxygen therapy) was connected to Resident 1. 2. Follow physician orders for Resident 1's oxygen administration and peripheral oxygen saturation (spO2-the percentage of oxygen-carrying hemoglobin in the blood with a normal level for healthy people typically 95-100 percent [&-unit of measurement]) monitoring. These deficient practices had the potential for Resident 1 to experience shortness of breath, respiratory distress, and negatively affect Resident 1's well-being. Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted Resident 1 on 7/11/2025 and readmitted on [DATE], with diagnoses including chronic obstructive pulmonary disease (COPD- a progressive lung disease that blocks airflow, making breathing difficult), acute respiratory failure (a severe condition where lungs can't adequately oxygenate blood or remove carbon dioxide, requiring emergency care), and unspecified dementia (a progressive state of decline in mental abilities). During a review of Resident 1's Care Plan, last revised on 11/8/2025, the Care Plan indicated Resident 1 had oxygen therapy related to respiratory illness. The Care Plan interventions indicated to give Resident 1 medications as ordered by the physician and return Resident 1 to usual oxygen delivery method after the meal. During a review of Resident 1's History and Physical (H&P), dated 11/22/2025, the H&P indicated Resident 1 was able to make needs known but did not have the capacity to make medical decisions. During a review of Resident 1's Minimum Data Set (MDS-resident assessment tool), dated 11/13/2025, the MDS indicated Resident 1 had severely impaired cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS indicated Resident 1 required maximal assistance (helper does more than half the effort) from the facility staff with toileting hygiene, showers, and lower body dressing. During a review of Resident 1's Physician Order Summary Report, the Order Summary Report indicated the following physician's order: -11/9/2025: Obtain peripheral oxygen saturation (spO2) every shift. -11/9/2025: Oxygen: Oxygen at two liters (L-unit of volume measurement) per minute, via nasal cannula (a medical device that provides supplemental oxygen therapy) continuously-11/20/2025: Oxygen: Oxygen at 2L per minute via nasal cannula every shift. a. During a concurrent observation and interview on 12/2/2025 at 10:37 a.m. with Licensed Vocational Nurse (LVN) 1 in Resident 1's room, Resident 1 was observed lying in bed. Resident 1's nasal cannula was observed away from the resident, wrapped around the oxygen concentrator. The oxygen concentrator was observed to be turned off. LVN 1 stated Resident 1 was not connected to the oxygen. LVN 1 stated facility staff should have made sure that Resident 1's nasal cannula was connected to Resident 1, and the concentrator was turned on after providing care to Resident 1. LVN 1 Resident 1 had the potential to experience low oxygen levels, altered level of consciousness, and respiratory decline. During an interview on 12.2.2025 at 12:29 p.m. with Registered Nurse (RN) 1, RN 1 stated the facility staff failed to administer oxygen to Resident 1 as ordered by the physician. RN 1 stated this failure had the potential to place Resident 1 to experience low oxygen level and respiratory failure. During a review of the facility-provided policy and procedure (P&P) titled, Oxygen Administration, last revised on 7/3/2025, the P&P indicated, Check the tubing connected to the oxygen cylinder to assure that it is free of kinks.Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered. Check the mask, tank, humidifying jar, etc. , to be sure they are in good working order and are securely fastened. During a review of the facility-provided policy and procedure (P&P) titled, Administering Medication, last revised on 7/3/2025, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. b. During a concurrent interview and record review on 12/2/2025 at 12:29 p.m. with RN 1, Resident 1's Medication Administration Record (MAR), dated 11/2025 was reviewed. The MAR indicated, on 11/11/2025 for the day shift (7a.m. to 3 p.m.) administration time, 11/12/2025, 11/13/2025 day and evening shift (3 p.m. to 11 p.m.) administration time, and 11/14/2025 for day and evening shift administration time, there were no licensed staff initials in the box for Resident 1's 2L of oxygen, to demonstrate the oxygen was administered. The MAR indicated, on 11/11/2025 for the day shift (7a.m.-3 p.m.) administration time</p>		