STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675306	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bluebonnet Nursing & Rehabilitation	696 Fm 99 Karnes City, TX 78118

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health and safety of the resident or others for 1 of 4 residents (Resident #1) reviewed for call light placement. The facility failed to ensure the call light was within reach for Resident #1. This failure could place residents at risk of not receiving needed care and services in a timely manner The findings included: Record review of Resident #1's face sheet dated 6/2/26 reflected an [AGE] year old female admitted into the facility on 7/29/25 and re-admitted on [DATE] with diagnoses that included visuospatial deficit and spatial neglect following cerebral infarction (problems identified after a stroke that consist of having trouble judging distances, and difficulty understanding where objects are in space and how they relate to each other), hemiplegia and hemiparesis affecting left non-dominant side (conditions that affect one side of the body; complete or nearly complete paralysis of one side of the body), muscle wasting and atrophy (wasting away, shrinking, or decrease in size of a body part, tissue, organ, or muscle), abnormalities of gait and mobility, and lack of coordination. Record review of Resident #1's most recent significant change MDS assessment dated [DATE] reflected the resident was moderately cognitively impaired for daily decision-making skills, had range of motion impairment to both the upper and lower extremity on one side, and required substantial/maximal assistance with mobility. Record review of Resident #1's comprehensive care plan with revision date 9/9/25 reflected the resident had an ADL self-care deficit with interventions that included to encourage the resident to use bell to call for assistance. Observation on 6/2/26 at 11:49 a.m. revealed Resident #1's soft-touch call light (a call device that can be activated with very little pressure or movement; designed for patients who have limited strength, mobility, or dexterity) was activated, and CNA D was observed entering the resident's room in response to the call light activation. Observation on 6/3/26 at 7:25 a.m. revealed Resident #1 in the bed and the soft-touch call light was seen on the resident's nightstand on the right of the bed and not within reach. During an observation and interview on 6/3/26 at 7:28 a.m., CNA E stated he did not generally work on the unit Resident #1 resided in and stated there were two CNA staff assigned to the unit. CNA E stated the morning shift started at 6:00 a.m., and the aides made rounds of the unit every two hours. CNA E stated when making rounds it consisted of ensuring fall prevention interventions were implemented, ensuring the residents were clean, and ensuring the call lights were within reach. During an observation of Resident #1, CNA E stated Resident #1's soft-touch call light was on the nightstand and not within the resident's reach. CNA E stated since the soft-touch call light was not within Resident #1's reach it was a problem because if she needed assistance or needed help, she could not receive the help she needed. CNA E stated if the call light was not provided to a resident within reach, and the resident was non-verbal, they could not call out for help. During an interview on 6/3/26 at 9:34 a.m., CNA F stated she started her shift at 6:00 a.m. and patient rounds were made every two hours. CNA F stated when making rounds on the unit it included ensuring resident call lights were within reach. CNA F stated Resident #1 could activate the call light and stated the soft-touch call light was provided to the resident because she could not use the left arm due to (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675306	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2026

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	paralysis but was able to use the right arm. CNA F stated the soft-touch call light was supposed to be placed on the resident's chest or by the right shoulder, that way she can activate it. CNA F stated she was not aware Resident #1's soft touch call light was on the nightstand, not within reach and stated the resident would not be capable of reaching the soft-touch call light from the nightstand. CNA F stated she had not made rounds on Resident #1 when her shift started at 6:00 a.m. because she was busy getting other residents out of bed. CNA F stated that residents call lights were supposed to be within reach so the residents could call for help. During an interview on 6/3/26 at 11:19 a.m., the Regional Compliance RN stated, call lights should be within reach because the residents have the right to receive the care they need when they need it. The Regional Compliance RN stated, if the residents did not have access to the call light, they won't receive the care they need in a timely manner. The Regional Compliance RN stated, the bad thing that could happen like with Resident #1 would be she could be in pain and not get pain medication. Record review of the facility document titled Resident Rights, undated, reflected in part, .A facility must 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.The facility must protect and promote the rights of the resident.Planning and implementing care.The right to receive the services and/or items included in the plan of care.The resident has the right to be treated with respect and dignity, including.The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences.

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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 0689 Level of Harm - 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** Based on interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents for 1 of 4 residents (Resident #1) reviewed for accidents and hazards. The facility failed to ensure Student Nurse Aide A was assisted by a second staff member while providing incontinence care to Resident #1 on the bed on 5/20/26. Resident #1 slid off the bed, fell to the floor and fractured her right leg. The noncompliance was identified as PNC on 5/20/26. The facility had corrected the noncompliance before the survey began on 5/28/26. This failure could place residents at risk of serious injury, harm, and/or death. The findings included: Record review of Resident #1's face sheet dated 6/2/26 reflected an [AGE] year old female admitted into the facility on 7/29/25 and re-admitted on [DATE] with diagnoses that included cerebral infarction due to embolism of bilateral middle cerebral arteries (a stroke cause by a loss of blood flow to part of the brain resulting in brain tissue damage or death; embolism refers to a blood clot lodged in an artery; bilateral middle cerebral arteries refers to the clot affecting both sides of the brain), hypertension (high blood pressure), depression, visuospatial deficit and spatial neglect following cerebral infarction (problems identified after a stroke that consist of having trouble judging distances, and difficulty understanding where objects are in space and how they relate to each other), obesity (excessive amount of body fat that may increase the risk of health problems), anxiety disorder, hemiplegia and hemiparesis affecting left non-dominant side (conditions that affect one side of the body; complete or nearly complete paralysis of one side of the body), muscle wasting and atrophy (wasting away, shrinking, or decrease in size of a body part, tissue, organ, or muscle), abnormalities of gait and mobility, lack of coordination, pain in unspecified joint. Record review of Resident #1's most recent significant change MDS assessment dated [DATE] reflected the resident was moderately cognitively impaired for daily decision-making skills, had range of motion impairment to both the upper and lower extremity on one side, required substantial/maximal assistance with mobility that included rolling left and right, and was always incontinent of bowel and bladder. Record review of Resident #1's comprehensive care plan with revision date 9/9/25 reflected the resident had an ADL self-care deficit with interventions that included 2-person assist with bed mobility, the resident required total dependence on staff to provide incontinent care of both bladder and bowel, and the resident required 2-person assist to reposition and turn in bed. Record review of Resident #1's Radiology Results Report dated 5/21/26 reflected the following:- Right Knee: acute appearing mildly displaced femoral metaphyseal fracture (a recent fracture located in the lower part of the thigh bone close to the knee in which the broken bone pieces have shifted out of their normal position)Record review of the Intake Investigation Worksheet Incident dated 5/21/26 reflected the incident had occurred on 5/20/26 at 8:30 p.m. and the narrative of the incident reflected, Resident #1 rolled out of bed during peri-care assistance attempting to ?assist staff' with turning. Staff member (Student Nurse Aide #A) turned to grab the brief and resident was sliding and aide could not catch her one (sic) time. During an interview on 6/2/26 at 11:49 a.m., Resident #1 stated she recalled an incident in which she had a fall but was unable to recall when or where the fall had occurred. Resident #1 stated she was incontinent and unable to get up by herself. Resident #1 stated she had tried to get up by herself, and that was probably why she fell. Resident #1 stated she did not have any broken bones. During an interview on 6/2/26 at 12:27 p.m., Student Nurse Aide A stated she was hired at the end of January 2026 as a nurse aide. Student Nurse Aide A stated, before the incident with Resident #1 in which the resident sustained a fracture from the fall while assisting the resident during peri care, Student Nurse Aide A stated she did not know she was not supposed to assist a resident with incontinent care without a second person. Student Nurse Aide A stated, the former DON didn't tell me that. Student Nurse Aide A (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	stated she was unaware Resident #1 required a two-person assist during care and had been providing incontinent care to the resident without staff assistance. Student Nurse Aide A stated, she helps me, referring to Resident #1 and stated the resident could turn and roll her leg over and she (Resident #1) does have a good side. Student Nurse Aide A stated, at the time of the incident, she was providing incontinent care to Resident #1 and she had the resident turn to her side, left side I think, and the resident was fine, and when the Student Nurse Aide turned a split second to retrieve the resident's brief, and when the Student Nurse Aide turned back around, the resident had fallen onto the left side and was between the wall and the bed. Student Nurse Aide A stated she had never been told by any of the CNAs that she worked with that she could not do any patient care by herself. During an interview on 6/2/26 at 1:33 p.m., CNA B stated, the student aides can only help and assist a certified nurse aide with patient care and cannot work by themselves. CNA B stated, Resident #1 required two-person assist with mobility and transfers. During an interview on 6/2/26 at 2:20 p.m., LVN C stated Resident #1 required two-person assistance when provided with incontinent care. LVN C stated the Student Nurse Aides were not allowed to provide direct care unless accompanied by a certified aide. During an interview on 6/2/26 at 1:23 p.m., the Administrator stated Resident #1 sustained a right knee fracture as the result of a fall. The Administrator stated Resident #1 was never sent to the hospital, but the facility obtained x-ray orders from hospice. During a follow-up interview on 6/2/26 at 2:28 p.m., the Administrator stated, when the student nurse aides completed the online program for CNA certification, the students were then sent to a sister facility to complete the required NATCEP skills training and then the facility in turn submitted the required documents of completion to the State to register the online test. The Administrator stated, during this process, the Student Nurse Aides were allowed to work the floor but were supposed to be accompanied by a certified aide. The Administrator stated, she believed Student Nurse Aide B had completed and passed the required proficiencies training prior to working with Resident #1 but stated she had not necessarily laid eyes on the proficiencies. The Administrator stated, Resident #1 was clearly a two-person assist. During a telephone interview on 6/2/26 at 5:26 p.m., the former DON stated she was employed by the facility in January/February of 2026 and recalled asking the Administrator and the Regional Compliance RN about the Student Nurse Aides obtaining certification and testing. The former DON stated she could not recall if the Administrator or the Regional Compliance RN had told her, if the Student Nurse Aides had completed their initial online training, and a facility nurse was on the schedule, then the Student Nurse Aides were allowed to work on the floor. The former DON stated she believed that meant, with a nurse working the floor, the Student Nurse Aide could depend on the floor nurse if there were any questions. The former DON stated she received a text message on 5/20/26 from the facility about Resident #1 having had an injury related to a fall and then contacted the Administrator to inform her of the incident. The former DON stated Student Nurse Aide A was the person involved in the incident with Resident #1. The former DON stated, I did not check if competencies had been done. I didn't check their competencies (Student Nurse Aides) because they had already been employees there. The former DON stated, as the DON she would not have allowed any student at any shift to do patient care, but there was always other CNAs and nurses in the building and there were other CNA staff scheduled on the day of the incident. The former DON stated she did not find out until the day after the incident, 5/21/26, during a conference call with the Regional Director, that no student was allowed to work on the floor until they had their competency training. The former DON stated they were instructed to pull the Student Nurse Aides off the floor until training had been completed. The former DON stated she had already given her 30-day notice of resignation, but after the incident she resigned on 5/21/26. The former DON stated she never told the Student Nurse Aides, or any of the CNA staff that the Student Nurse Aides could work the floor without a Certified Aide or nurse's supervision. The former DON stated, I believe there was just a miscommunication with the process. The former DON stated she did not know what her role was in managing the Student Nurse Aides and had asked that question in an e-mail to the Regional Compliance RN. The former DON stated she (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	would have to look for the e-mail but was unable to articulate what response was given about her responsibilities associated with the Student Nurse Aide training. During an interview on 6/3/26 at 8:55 a.m., the Regional Compliance RN stated the facility did not have a DON at this time and she and RN staff from sister facilities were providing coverage for the facility. The Regional Compliance RN stated, upon hire, the Student Nurse Aides complete the orientation process and were instructed on what they can and cannot do. The Regional Compliance RN stated, upon hire, if the Student Nurse Aide provided the facility with proof that the initial on-line ADL training for CNA certification had been completed, they were allowed to work on the floor under the supervision of a certified nurse aide. The Regional Compliance RN stated, at the time of the incident with Resident #1, Student Nurse Aide A, and the other Student Nurse Aide employed by the facility were pulled off the floor and she (The Regional Compliance RN) arranged to enroll and provided transportation to the NATSEP classes. The Regional Compliance RN stated she was not aware the Student Nurse Aides had not been enrolled in the NATSEP certified classes needed prior to scheduling for State testing until she investigated the matter into the incident with Resident #1 and Student Nurse Aide A. The Regional Compliance RN stated it was the former DON's responsibility to provide the necessary training needed for the Student Nurse Aides to complete the necessary training to schedule for testing. The Regional Compliance RN stated she was in communication with the former DON about following the process to obtain NATSEP training and certification for the Student Nurse Aides, including which sister facilities offered the NATSEP training but the former DON did not take initiative. The facility course of action prior to the surveyor entrance included:- The hospice staff, MD, and RP were notified of Resident #1's fall Record review of a facility document titled, Self-Reporting Protocol/Ad Hoc QAPI Fall from Bed During Care reflected the following:- Self-report to state completed 5/21/26- Suspend known perpetrators immediately pending investigation completed 5/21/26- Interview the resident completed 5/20/26- Take statements from all staff who were caring for Resident #1 during the incident completed 5/21/26- Interview other interviewable residents regarding staff treatment completed 5/21/26- Begin abuse/neglect in-service and/or assign an abuse related computer course started 5/21/26- In-service all nursing staff to the following with start date 5/21/26 and in-serviced by the Administrator and the ADON:1. use of the Kardex2. ensure the care plan is followed and interventions, including how many staff are required to perform an ADL and/or if they need a mechanical lift3. if unable to have the proper number of staff to assist a resident, do not perform the task until the proper number of staff is present; do not rush4. if the amount of staff assistance needed is not listed for bathing, bed mobility, transferring, walking, and incontinent care then contact the Charge Nurse and/or ADON 5. If more assistance is required than what is on the Kardex, report to the DON, ADON, or MDS case manager immediately so the Kardex can be adjusted, including if a staff feels additional staff were required to perform incontinent care while in bed 6. Maintain the resident in the center of the bed as much as possible when turning and repositioning and/or performing incontinent care7. Any resident on an air mattress needs at least 2 staff to assist with bed mobility and/or incontinent care in the bed. If the kiosk has more staff than 2 required, go with the higher number8. Licensed nurses - include to assess and manage pain and report uncontrolled pain to the MD or NP9. Non-licensed nursing staff - to report non-verbal signs of pain (crying, guarding, moaning, yelling out, grimacing, etc.) and verbal reports of pain to the charge nurse- Staff who are not in-serviced will be in-serviced prior to assuming their duties on their next scheduled shift. New and agency staff will also be in-serviced prior to assuming patient care duties- Initiate the following for monitoring: Monitoring = Documented1. The DON or designee will monitor at least 10 episodes of incontinent care or assist with bed mobility weekly to ensure staff is performing correctly and the care planned number of staff are assisting2. During incident/event review in standup, the DON and Administrator will monitor potential neglect in the event reports3. During facility rounds, note any corrective actions if there were signs of any staff performing or not performing their duties in a neglectful manner4. The DON or designee will interview at least 10 nursing staff per week to ask the questions: How do you know how much staff is required (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	to perform an ADL including turn and reposition and incontinent care? If a resident is on an air mattress, what is the minimum number of staff that must assist- all monitoring will continue for at least 4 weeks. - All items should be in a binder/folder for ease of review and to give to the state upon their investigation Record review of the facility document titled Employee Disciplinary Report dated 5/20/26 reflected Student Nurse Aide A was placed on an investigatory suspension pending an investigation into allegations of resident mistreatment signed by the former DON on 5/21/26 and the record showed Student Nurse Aide A was notified by phone on 5/21/26. Record review of the facility document titled Resident Abuse Interview and Observation, dated 5/21/26 reflected 9 residents were interviewed and no negative effects were noted. Record review of the facility document titled Monitoring reflected monitoring was conducted between 5/21/26 to 5/27/26 and revealed the following:1. The DON or designee will monitor at least 10 episodes of incontinent care or assist with bed mobility weekly to ensure staff is performing correctly and the care planned number of staff are assisting. Was it performed correctly? Yes or No. If no, state corrective action on the back of the form. The document did not show any negative effects.2. During incident/event review in standup, was there any evidence of any potential neglect? The document did not show any negative effects.3. During facility rounds, are there any signs of staff performing or not performing their duties in a neglectful manner? Note any corrective actions. The document did not show any negative effects. Record review of the facility staff roster reflected there were 21 direct care nursing staff on the Roster.- All staff were in-serviced beginning 5/21/26 to 5/22/26 on the following:ANE, Fall Prevention, Utilization of the Kardex (a nursing documentation tool used in healthcare settings to quickly summarize key patient information in a concise, organized way) for Direct Care Staff, Change of Condition after a Fall.- 15 direct care staff were interviewed from 6/2/26 to 6/3/26 and were knowledgeable of the protocols in-serviced that were related to the incident- The Corporate Compliance RN scheduled NATSEP training for all three Student Nurse Aides employed by the facility which was completed at the time of the investigation. At the time of the investigation, the three Student Nurse Aides were awaiting approval from the State to schedule the testing for certification. Record review of the facility document titled Student Nurse Aide Protocol: Orientation to Floor, undated reflected in part, .Initial Hiring Status.Applicants interested in becoming Certified Nurse Aide (C.N.A.) will initially be hired as a Hospitality Aide unless they have already completed their clinical skills through a NATCEP (Nurse Aide Training and Competency Evaluation Program).Student aides will be assigned to work under the supervision of a certified nurse aide during their training period.Scope of Practice.Student aides are only permitted to perform skills that have been formally checked off and approved.Completion of Clinical Education.Student Aides must complete their clinical education through the NATCEP program as soon as possible. Record review of Student Nurse Aide A's Texas Nurse Aide Performance Record, Form 5497- NATCEP with Training Begin Date 5/22/26 and Training End Date 5/28/26 reflected the requirements for providing patient care which included incontinent care and positioning residents and moving residents in bed were successfully completed. Record review of Student Nurse Aide A's notarized Certificate of Completion document reflected that she had successfully completed the course of clinical hours for the Nurse Aide Training and Competency Evaluation Program (NATCEP) 5/22/26 thru 5/28/26. Record review of the facility document titled Resident Rights, undated reflected in part, .A facility must 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.Planning and implementing care.The right to receive the services and/or items included in the plan of care. Record review of the facility document titled Fall Policy, undated reflected in part, .Preventing falls requires an interdisciplinary program that focuses on modifying the extrinsic factors, correcting intrinsic factors, and educating the resident.Environmental.Staff must be trained in safe transfer techniques and proper use of body mechanics.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain medical records on each resident that were complete and accurately documented for 1 of 4 residents (Residents #1) reviewed for medical records. The facility failed to ensure Resident #1's physician's orders were updated to include the resident was treated with oxygen therapy. This deficient practice could place residents at risk of improper care due to inaccurate medical records.The findings included: Record review of Resident #1's face sheet dated 6/2/26 reflected an [AGE] year old female admitted into the facility on 7/29/25 and re-admitted on [DATE] with diagnoses that included gastro-esophageal reflux disease (a chronic acid reflux from the stomach into the esophagus with symptoms that include chronic cough, and difficulty swallowing), gastrostomy status (a surgically created opening through the abdomen into the stomach to provide nutrition, fluids, or medications when a person cannot eat or swallow safely by mouth with common symptoms that include chronic cough or hoarseness), and respiratory disorders. Record review of Resident #1's most recent significant change MDS assessment dated [DATE] reflected the resident was moderately cognitively impaired for daily decision-making skills. Record review of Resident #1's Order Summary Report dated 6/2/26 for Active Orders As Of 5/1/26 reflected there was no physician's order for the use of oxygen. Record review of Resident #1's Order Summary Report dated 6/2/26 for Active Orders As Of 6/1/26 reflected there was no physician's order for the use of oxygen. During an observation on 6/2/26 at 10:05 a.m., Resident #1 was observed sleeping in the bed and the O2 concentrator was operating via a nasal cannula at 2 liters per minute. Resident #1 had a suction machine on the nightstand on the right side of the bed. During an observation and interview on 6/2/26 at 11:49 a.m., Resident #1 was observed awake on the bed and the O2 concentrator was operating via a nasal cannula at 2 liters per minute. Resident #1 was unable to articulate why she was receiving oxygen and stated she had been using oxygen for maybe over a month. During an interview on 6/2/26 at 12:12 p.m., CNA D stated she believed Resident #1 had been receiving oxygen treatments and had noticed the resident had been using oxygen for about three months. During an interview on 6/2/26 at 12:27 p.m., Student Nurse Aide A stated she believed Resident #1 had been receiving oxygen treatments for at least a few months. Student Nurse Aide A stated, only the nursing staff were allowed to take care of the oxygen concentrator. During an observation on 6/2/26 at 3:14 p.m., Resident #1 was observed on the bed and the O2 concentrator was operating via a nasal cannula at 2 liters per minute. During an interview on 6/2/26 at 3:15 p.m., LVN G stated Resident #1 had been receiving oxygen treatments for maybe a month. LVN G stated he was not sure if the hospice staff had set up the oxygen concentrator for the resident. LVN G stated he monitored Resident #1's vital signs every morning which included obtaining the residents oxygen level readings. LVN G stated the settings on the oxygen concentrator used by Resident #1 was already set up when he arrived to work the morning shift and only checked the resident's oxygen levels and the oxygen concentrator tubing was checked by the night shift staff. LVN G reviewed Resident #1's orders in the electronic record and stated there was no order for Resident #1 to use oxygen. LVN G stated there was supposed to be an order for the oxygen for Resident #1 because it was considered a treatment. LVN G stated he would obtain the oxygen order from the hospice staff. LVN G did not articulate why the order for the use of oxygen for Resident #1 was not obtained prior to use. During an interview on 6/2/26 at 3:26 p.m., the Regional Compliance RN stated, Resident #1 was receiving hospice services, and the use of an oxygen concentrator was standard for residents receiving hospice services. The Regional Compliance RN stated she had not been caring for Resident #1 and was unsure how long the resident had been receiving oxygen therapy. The Regional Compliance RN stated there should be a physician's order for oxygen treatments, but in Resident #1's case, the oxygen would probably help, but getting the physician's order was standard (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	practice. The Regional Compliance RN stated it was the responsibility of the nurse to obtain orders and to check the resident receiving oxygen treatments. During a follow up interview on 6/3/26 at 3:33 p.m., LVN G stated he placed a call to hospice and determined there was an order for oxygen for Resident #1 as needed, but it never got transcribed into the record. LVN G stated, Resident #1 went to the hospital in March 2026 and the order for oxygen probably got dropped. Record review of the facility document titled Medication Orders dated 3/2025 reflected in part, .Medications are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribed. Verbal orders are received only by licensed nurses or pharmacists and confirmed in writing by the prescriber within five (5) business days or per the specific States regulations if differs or is more stringent.Documentation of the medication order.Each medication order is documented in the resident's medical record with the date, time, and signature of the person receiving the order. The order is recorded on the current physician order sheet, the telephone order sheet, if it is a verbal order, and the Medication Administration Record (MAR).