STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115429	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cordele Health and Rehabilitation	1106 North 4th Street Cordele, GA 31015

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 52213 Based on observations and staff interviews, the facility failed to maintain a clean, sanitary, and comfortable environment for three of 13 resident rooms (room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER]) reviewed. Specifically, the PTAC (Packaged Terminal Air Conditioner) vents were dirty. This deficient practice had the potential to compromise the health and safety of residents and staff by increasing the risk of respiratory and allergy symptoms due to inadequate air filtration and reduced fresh air circulation. Findings include: Review of the undated facility- provided document titled PTAC Preventative Maintenance Guide under the Three-Monthly PTAC Air Cleaning Tasks section revealed, 1. Air Filter Clean the filter with a vacuum or running water. 2. Vent Screen Clean or replace the vent screen. Remove the front grille and clean it with a dampened cloth Review of the undated facility-provided document titled HVAC (heating, ventilation, and air conditioning): Clean Air Filters details the following steps, At a minimum, air filters are to be replaced or thoroughly cleaned depending on the type of filter every month. Clean evaporator coils if lint build up is present. Observations on 4/1/2025 between 9:00 am and 10:00 am of the facility's PTAC air filters in resident room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER] revealed that the PTAC units in these rooms had heavily soiled air filters with a thick accumulation of dust, dirt, and debris. Originally white, the air filters appeared dark gray due to trapped contaminants. When lifted for inspection, they released visible dust clouds and were clogged with a dense layer of grime. During an interview on 3/19/2025 at 9:35 am with Housekeeper II and Housekeeper JJ, they revealed that they did not clean the air filters. However, they did clean the grills, wiping them daily when they cleaned the rooms. During an interview on 4/3/2025 at 10:50 am with the Director of Housekeeping and the Director of Maintenance, they confirmed during a facility tour that maintenance was responsible for cleaning the air filters in the PTAC units. The maintenance staff cleaned the grills on the air filter covers as needed.

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 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** 48338 Based on staff interviews, record review, and review of the facility policy titled, (Long Term Care [NAME] Data Set) LTC MDS and Care Plan, the facility failed to follow the care plan for one of eight residents (R) (R168) and failed to include a care plan for O2 use with interventions for one of eight R (R37) who receive (O2) therapy. The deficient practice had the potential for R168 and R37's oxygen needs to go unmet. Findings include: Review of the facility policy titled LTC MDS and Care Plan with a revision date of December 2023 revealed under the Care Plan section: It is the policy of the facility to promote seamless interdisciplinary care for our residents by utilizing the interdisciplinary plan of care based on assessment, planning, treatment services, and interventions. 1. Review of the Care Plan dated 3/17/2025 for R168 revealed a focus diagnoses of emphysema/chronic obstructive pulmonary disease related to smoking. An intervention for oxygen setting revealed oxygen settings as ordered. Review of the Medication Administration order revealed the physician's order for Continuous oxygen @ (at) 2L/M Liters (L), minute (M), (Nurse is responsible for checking and maintaining Treatment Administration Record (TAR) every shift (QS). Administration Record (TAR) every shift (QS). She said she did not check the care plan, nor follow it as stated. An interview with the Director of Nursing (DON) on 4/3/2025 at 11:00 am revealed her expectations of the nurses following Doctor's orders and regulating O2 or any medication, she expected the nurses to access the Provider, change the settings when ordered, and alter the Care Plan to address those changes so that it flowed with the doctor's orders. 52213 2. An observation on 4/1/2025 at 9:30 AM revealed and unsecured oxygen tank in Resident (R) (37), room [ROOM NUMBER]. The oxygen cylinder was noted to be in front of R 37's dresser drawers standing upright. No nasal cannula or nebulizer was attached the cylinder. A review of the physician's orders for R37 confirmed an O2 order. Review of the care plan for R37 revealed no care plan was in place for the resident's O2. An interview on 4/3/2025 at 1:40 pm with the MDS Director revealed that R37 was care planned for O2 at 3 LPM. The intervention states that on 7/5/2024, the resident was admitted to the hospital: Low O2 on 3 liters via nasal cannula (81%) admitted to room number DX: Dyspnea/COPD without exacerbation with low saturation. She verified that the resident was ordered for O2 at 2 liters. It was her expectation that care plans contained the correct information that was resident centered.

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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** 52213 Based on observations, staff interviews, record review, and review of the facility policy titled, Medical Gas Cylinder Storage, the facility failed to ensure an oxygen (O2) tank was properly secured for one of five residents (R) (R37) reviewed for O2 storage. The deficient practice had the potential to result in harm or injury to the facility's residents. Findings include: Review of the facility policy titled Medical Gas Cylinder Storage dated February 2025 revealed under 2.0 General Requirements: All freestanding oxygen cylinders shall be in a rack, on a cart, in a portable cylinder holder, in a gas cylinder storage cabinet, or secured with a chain to protect them. Review of the electronic medical record (EMR) revealed that R37 was admitted to the facility with diagnoses of, but not limited to dependence on supplemental oxygen, dyspnea (shortness of breath), pneumonia (recurrent), Alzheimer's disease, chronic obstructive pulmonary disease (COPD), type 2 diabetes mellitus, dementia, unspecified. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for R37 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Section GG (Functional Status) revealed need for supervision to partial assistance for ADLs (activities of daily living). An observation on 4/1/2025 at 9:30 am revealed an unsecured O2 tank/cylinder in R37's room, room [ROOM NUMBER]. The O2 tank was noted to be in front of R37's dresser drawers standing upright, unsecured. No nasal cannula or nebulizer were attached to the O2 cylinder. During an interview on 4/3/2025 at 11:50 am with Certified Nurse Aide (CNA BB), she stated all O2 cylinders/tanks should be secured to the chairs or stored in the supply room. She stated, When a cylinder gets empty, we take it and replace it. She confirmed there should not be an extra cylinder in resident rooms and cylinders should be stored in a rack or attached to a resident's wheelchair. She confirmed O2 cylinders were not to be stored in resident rooms. During an interview on 4/3/2025 at 1:30 pm with the Director of Nursing (DON), she stated it was her expectation for O2 cylinders to be stored in the supply room if not secured when in use by a resident.

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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** 50171 Based on observations, resident and staff interviews, record review, and review of the facility's policies titled, Oxygen (O2) Concentrator and LTC (long term care)-Oxygen, the facility failed to ensure that residents received O2 as ordered for two of eight residents (R) (R29 and R168) receiving O2 therapy; and failed to ensure that the O2 concentrator (machine that supplies O2) was clean, sanitary, and free of sediment build-up for one of eight R (R33) receiving O2 therapy. The deficient practice had the potential to put the residents at risk for medical complications such as hypoxia, respiratory depression, and infection. Findings include: Review of the facility's policy titled Oxygen Concentrator last revised 3/5/2024 documented under Policy Explanation and Compliance Guidelines: Oxygen is administered under orders of the attending physician. Care of the Concentrator: Follow manufacturer recommendations for the frequency of cleaning filters and servicing the device, external filters will be cleaned weekly. Only trained individuals, such as the Maintenance Director or supplier, shall service the device. The Housekeeping Department Responsibilities: Clean the outside casing of the concentrator and nebulizer units during routine room cleaning with an EPA-(Environmental Protection Agency) registered disinfectant in accordance with label instructions. Review of the facility's policy titled LTC-Oxygen dated April 2025 revealed under Policy Subject: Oxygen: . 1. There must be a physician's order for oxygen use which includes the route and liter flow or specific oxygen concentration, and how long the oxygen is to be administered. Review of the electronic medical record (EMR) revealed R29 was admitted with diagnoses of, but not limited to anemia, heart failure, hypertension, diabetes mellitus, multiple sclerosis (MS). Review of the Minimum Data Set (MDS) revealed in Section C (Cognitive Patterns) a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Section GG (Functional Abilities and Goals) revealed R29 required substantial/maximal assistance with shower/bath and tub/shower transfers, Section J (MDS) revealed shortness of breath (SOB) with exertion, sitting and lying flat. Resident is on oxygen (O2) therapy. 1. Interview/observation on 4/1/2025 at 10:45 am with R29 revealed that his O2 should be set at 3 liters per minute (LPM), and he did not change it. He went on to reveal that the staff changed his O2 tubing every Sunday, as well as the water for the humidifier. R29's O2 was observed to be set at 3 LPM, the water bottle for the humidifier was dated 3/31/2025, and there was no label/date on the tubing showing when it had been changed. Observation on 4/1/2025 at 12:15 pm, R29's O2 was set at 3 LPM, the tubing was still unlabeled. Observation on 4/3/2025 at 11:15 am revealed R29's O2 was set at 2 LPM. The O2 tubing had been changed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/2/2025 at 4:15 pm with the Director of Nursing (DON) revealed that it was her expectation that the physician orders be followed and if there needed to be a change, they should contact the physician to inform them if a change was needed. 52213 2. Review of the EMR for R33 revealed that the resident was admitted to the facility with diagnoses that included but were not limited to paroxysmal atrial fibrillation, anemia, deep vein thrombosis (DVT), hypertension, ulcerative colitis, thyroid disorder, anxiety, depression, obstructive sleep apnea, and a multiple drug resistant organism in a wound, presence of a cardiac pacemaker, congestive heart failure, herpes zoster keratitis, Parkinsonism, chronic obstructive pulmonary disease (COPD) and insomnia. Review of the annual MDS dated [DATE] for R33 revealed in Section C (Cognitive Patterns), a BIMS score of 15, indicating intact cognition. Section J (MDS): Received as needed medication, shortness of breath (SOB) with exertion, sitting and lying flat. Resident is on oxygen (O2) therapy. Oxygen settings: O2 via nasal canula (NC) at 3 liters per minute (LPM). Observation on 4/1/2025 at 9:30 am revealed R33 lying in bed with O2 tubing on. The O2 concentrator was noted to be on and running with fluffy, brown/gray/white substance covering the filter area and the entire machine. Observation on 4/2/2025 at 8:55 am revealed R33 lying in bed with the O2 concentrator running with fluffy brown/gray/white substance covering machine and filter area. Observation on 4/3/2025 at 11:15 am revealed R33 lying in bad using the O2 concentrator, with the O2 concentrator filter covered with fluffy, light-brown and white substance. Interview on 4/3/2025 at 10:55 am with the Maintenance Director revealed the facility's policy was that housekeeping was to clean O2 concentrators weekly when O2 was in use. He also stated that the O2 provider was responsible for maintaining and changing the filter on each concentrator. He stated that his expectation was for the O2 provider to come in and complete regular cleaning and maintenance. 48338 3. Review of the EMR for R168 revealed he was admitted with diagnoses including but not limited to diabetes mellitus, sepsis, hypertension, and chronic obstructive pulmonary disease (COPD). Review of the Admission MDS dated [DATE] for R168 revealed in Section C (Cognitive Patterns) a BIMS score was not coded; section GG indicated eating/oral hygiene was independent; shower/bath dependent; toileting hygiene, upper/lower body dressing, and personal hygiene, required assistance. Review of the care plan dated 3/17/2025 revealed a focus area where R168 removes nasal cannula and changes the oxygen setting. The interventions revealed the oxygen setting was oxygen as ordered by the physician. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician's orders for R168 revealed on 4/2/2025 at 8:50 am during medication observation with Licensed Practical Nurse (LPN) AA, the order read, Continuous oxygen @ 2L/M (liters/minute), (Nurse is responsible for checking and maintaining Treatment Administration Record (TAR) every shift (QS). LPN AA said she did not follow the care plan as ordered. When asked what she would do going forward, she said she would notify the MD (medical doctor) to get an order to cover the titration when he removed his O2 and follow the care plan. An observation of the Medication Administration Record (MAR) revealed an order on the resident's list of medication that read, Continuous oxygen 3L-4L/NC. Observe that the resident is wearing nasal cannula (NC) every 2 hours. Document oxygen saturation. The start date and time was 4/2/2025 at 12:00. The second order read, May increase oxygen to 4L if R168 has desaturation-stat episode, as needed for Shortness of Breath (SOB). The start date was 4/2/2025 (at) 12:15 PM. An observation on 4/2/2025 at 9:10 am revealed the nurse placed her meds on the overbed table and helped R168 in the bathroom. She also took an O2 tank and tubing to the bathroom because the resident was not wearing it in the bathroom. The rate was set at 3.5 LPM and she said when R168's O2 saturation dropped, they bumped it up to 4 LPM. At 9:12 am, the O2 rate was increased to 4 LPM on the concentrator. The O2 rate remained at 4 LPM on the concentrator. Review of the physician's orders for R168 revealed an order that read, Continuous oxygen 3L-4L/NC. Observe that the resident is wearing NC every 2 hours. Document oxygen saturation (O2 sat) percentage. The start date and time was 4/2/2025 at 12:00. The second order read, May increase oxygen to 4L if resident has had a desaturation stat-episode, as needed for Shortness of Breath (SOB). The start date was 4/2/2025 @ 12:15 PM. An interview on 4/3/2025 at 11:00 am with the DON revealed her expectations of the nurses following Doctor's orders and administering medications as prescribed. She said the nurses were to ensure what the resident was on exactly what was ordered. She said she expected the tubing to be labeled and dated for O2 and the humidification bottle to be labeled as well. She said she expected the used tubing to be labeled and bagged for disposal. She said if there was an issue with regulating O2 or any medication, she expected the nurse to access the Provider and change the settings when ordered.

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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. 44959 Based on observations, staff interviews, and review of the facility policy titled, Dietary Cleaning, the facility failed to ensure that the walk-in refrigerator, the oven, and the fryer were kept clean and sanitary, in a manner that prevents foodborne illness to the residents. This deficient practice had the potential to affect 56 of 62 residents who receive food from the kitchen. Findings include: A review of the facility policy titled Dietary Cleaning revealed: Creating a kitchen cleaning policy for a long-term care facility is essential to maintaining food safety, hygiene, and overall health. Under objective: The objective of this policy is to establish clear guidelines for maintaining a clean, sanitary kitchen environment to prevent food borne illness and ensure the health and safety of residents, staff, and visitors. Under General Guideline: All kitchen surfaces, utensils, equipment, and food storage areas must be kept clean and sanitized. During an initial walk through the kitchen on 4/1/2025 at 9:00 am with the Dietary Manager (DM) the following observations were made: Both ovens had burnt food stains, the fryer had debris, and the oil was dark colored. The side of the stove by the fryer had built up dirt and greasy substance. The walk-in fridge was very dirty with food debris, the floor was unkept with debris and the shelving was rusted. The DM acknowledged that the oven and the fryer were dirty as well as the walk-in fridge. A follow up walk through on 4/2/2025 at 9:10 am of the main kitchen revealed all previous observations remained, including stains built-up by the stove. All observations were confirmed with the DM during the walk through. Interview on 4/2/2025 at 9:40 am with the DM regarding her expectation of dietary staff maintaining a clean, sanitary environment in the kitchen. She stated that she expected staff to clean the refrigerator daily and deep clean it once a week and clean the oven daily and deep clean it once a week. She also stated that the fryer should be kept clean as well. Interview on 4/3/2025 at 12:50 pm with the facility Administrator regarding her expectations of staff when it came to maintaining a clean and sanitary environment with food storage, she revealed that the kitchen staff had a cleaning schedule, and she expected staff to wipe down everything at end of the day. She stated that she expected them to follow the cleaning schedule. She stated that the walk-in refrigerator should be cleaned on a monthly rotation and if staff walked in and observed something that needed immediate attention, that it should be addressed right away.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48338 Based on observations, staff interviews, and review of the facility's policy titled, Hand Hygiene and Policy Procedure, the facility failed to ensure the infection control process was followed for two residents (R) (R48 and R168) during medication observation. The deficient practice had the potential to spread infection to other residents, staff and visitors. Findings include: Review of the facility policy titled Hand Hygiene dated 8/4/2011 revealed under Purpose: To decrease the risk of transmission of infection by appropriate hand hygiene. Section 2: Waterless Handwashing Products: If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in all clinical situations other than those listed under Handwashing. Review of the facility policy titled Policy Procedure dated 3/2023 revealed under Procedure: . 3. The facility will provide personal protective equipment (PPE) to support compliance with standard and transmission-based precautions and ensure that it is readily available for staff use. Staff are required to adhere to standard precautions and use PPE according to standard precautions. An observation on 4/2/2025 at 8:42 am revealed Licensed Practical Nurse (LPN) AA drew up the heparin for R48 and cleansed the top of the vial, dialed the 2U (units) for waste in the Insulin Pen and extracted it, then dialed 5U of Lantus insulin via pen. She then pulled and set up her medication using the same gloves she drew heparin and dialed the insulin pen. An observation on 4/2/2025 at 9:10 am revealed LPN AA placed medications on the overbed table and helped R168 in the bathroom. She also took an O2 tank and tubing to the bathroom because the resident was not wearing it in the bathroom. She assisted R168 back to bed with the same gloves and gave him the fluticasone nasal spray one puff in each nostril. She then gave R168 a Spiriva inhaler one spray by mouth using the same gloves. She placed the mask for the albuterol inhaler over the nasal cannula (NC) for O2 and turned it on for 15 minutes. She then removed her gloves and sanitized her hands. An interview on 4/2/2025 at 9:30 am with LPN AA, she revealed she should have sanitized her hands and changed her gloves after she drew the injections, and before she set up her pills to avoid contamination with R48. She also said that she should have doffed (taken off) her gloves and washed her hands once she finished assisting R168 in the bathroom and before she gave her oral medication. An interview on 4/3/2025 at 11:00 am with the Director of Nursing (DON), she stated prior to the nurse giving the medication, she expected them to sanitize and/or wash their hands when taking care of residents and then giving medications. She said she expected them to change gloves between routes of medication and/or wash their hands to avoid cross-contamination.