STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115612	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warner Robins Rehabilitation Center	1601 Elberta Road Warner Robins, GA 31088

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** 50940 Based on observations, staff interviews, and review of the facility's policy titled Oxygen Administration via Concentrator, the facility failed to ensure that oxygen therapy was administered in accordance with the physician's orders for two of 23 residents (R) (R77 and R29) with physician's orders for oxygen (O2) therapy. The deficient practice had the potential to place R77 and R29 at risk of respiratory complications and unmet needs. Findings include: Review of the facility's policy titled Oxygen Administration via Concentrator, revised 8/2023, revealed the Procedure section included, .2. Turn the proper flow rate as ordered by the physician. 1. Review of R77's clinical record revealed diagnoses including, but not limited to, chronic obstructive pulmonary disease (COPD), pulmonary fibrosis, and dyspnea. Review of R77's Quarterly Minimum Data Set (MDS), dated [DATE], revealed Section C documented a Brief Interview for Mental Status (BIMS) score of 3 (indicating severe cognitive impairment). Section GG (Functional Abilities and Goals) documented R77 required substantial to maximal assistance with mobility. Section O (Special Treatments, Procedures, and Programs) documented R77 received O2 therapy while a resident at the facility. Review of R77's care plan revealed a Focus area of the resident was on O2 therapy related to shortness of breath. Interventions included administering O2 therapy during meals as ordered. Review of R77's Physicians' Orders revealed an order dated 12/14/2023 for O2 via nasal cannula (NC) at 3 liters per minute (LPM). Observations on 4/14/2025 at 11:52 am, 4/14/2025 at 5:17 pm, 4/15/2025 at 9:20 am, and 4/15/2025 at 2:31 pm revealed R77 receiving O2 via a NC at 4 to 4.5 LPM. In an interview on 4/15/25 at 2:33 pm, Licensed Practical Nurse (LPN) FF stated that residents received O2 according to the physicians' order. (continued on next page)

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

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/15/25 at 2:14 pm, the Director of Nursing (DON) stated that O2 should be administered according to the physician's order. She confirmed that R R77 would not be able to adjust the flow meter on the O2 concentrator. The DON confirmed pictures of R77's O2 flow meter set at 4 to 4.5 LPM. 51557 2. Review of R29's electronic medical record (EMR) revealed R29 had diagnoses including, but not limited to, malignant neoplasm of the lung. Review of R29's Admission Minimum Data Set (MDS) assessment, dated 2/18/2025, revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) of 3 (indicating severe cognitive impairment). Section O (Special Treatments, Procedures, and Programs) documented R29 received O2 therapy while a resident at the facility. Review of R29's Physician's Orders' revealed an order dated 3/20/2025 for O2 via NC at 2 LPM as needed for shortness of breath. Observations on 4/14/2025 at 11:59 am and 4/15/2025 at 9:34 am revealed R29 was receiving O2 at 3 LPM via a NC. In an interview on 4/15/2025 at 10:02 am, LPN DD revealed that the licensed nurses were responsible for setting and monitoring the flow rate of the O2. LPN DD stated he did not always look at the setting when providing care to a resident. In a concurrent observation and interview on 4/15/2025 at 12:15 pm, LPN EE confirmed R29's O2 was being administered at 3 LPM. LPN EE stated nurses were responsible for checking that the flow rate was according to the physician's orders. In an interview on 4/15/2025 at 12:50 pm, the DON revealed her expectation was for the licensed nursing staff to monitor the O2 flow rate and follow the physician's orders.

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51853 Based on staff interviews and record reviews, the facility failed to ensure laboratory tests were conducted in accordance with professional standards for one of 53 sampled residents (R) (R70). This deficient practice had the potential to place R70 at risk of medical complications, unmet needs, and a diminished quality of life. Findings include: Review of R70's Admission Record revealed diagnoses including, but not limited to, type 2 diabetes. Review of R70's Significant Change Minimum Data Set (MDS) assessment dated [DATE] revealed Section N (Medications) documented that R70 received insulin injections on seven of the seven days during the look-back period. Review of R70's Physician's Orders revealed an order dated 1/25/2025 for Tresiba subcutaneous (SQ) solution (a medication used to control high blood sugar) 100 unit/ml (milliliter), inject 35 units SQ each am. Further review of the orders revealed no order for daily blood sugar checks. In an interview on 4/15/2025 at 12:30 pm, LPN AA verified R70 received insulin injections and did not have physician orders for daily blood sugar checks. In an interview on 4/15/2025 at 1:51 pm, the Director of Nursing (DON) verified R70's physician's orders of insulin injections and further verified there was no order for daily blood sugar monitoring. The DON stated R70's physician's orders should include blood sugar checks before meals and at bedtime. She stated the nurses were responsible for ensuring an order for blood sugar checks for residents who received insulin. In an interview on 4/16/2025 at 9:21 am, the Administrator stated the Unit Manager and the DON were responsible for checking physician orders. In an interview on 4/16/2025 at 9:36 am, Licensed Practical Nurse (LPN) II stated that if a resident received insulin injections, she would expect a physician's order for blood sugar checks. She further stated there were standing orders for blood sugar checks, and residents who received insulin should have the order initiated.