STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375306	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cordell Nursing and Rehabilitation	1400 North College Cordell, OK 73632

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation and interview, the facility failed to ensure:a. showers were cleaned between each use, andb. the walls of residents' rooms were not damaged during 2 of 2 observations made for a clean, sanitary, and home like environment.The administrator identified 53 residents resided in the facility.Findings:1. On 09/04/25 at 9:40 a.m., Resident #52's room was observed to have two areas 6 inches by 18 inches of damaged sheetrock and missing paint on the wall where the bed was against the wall. Resident #52 quarterly assessment, dated 07/10/25, showed their cognition was intact with a BIMS score of 15. The assessment showed Resident #52 was dependent for transfers. On 09/03/2025 at 9:40 a.m., Resident #52 stated the wall has been damaged like that for 6 years caused by the bed reclining up and down. Resident #52 stated the facility replaced the floor recently and were aware of the damage to the wall but did not repair the wall. Resident #52 stated the wall damage has been reported to multiple staff, but it has never been repaired. Resident #52 stated they did not like the wall being damaged. 2. On 09/04/25 at 9:45 a.m., Resident #9's room was observed to have one area 6 inches by 8 inches of damaged sheetrock and missing paint on the wall where the bed was against the wall. 09/04/25 at 10:05 a.m., work orders were reviewed. There were no open work orders for sheetrock/wall repair in Resident #9 and Resident #52's rooms. On 09/04/5 at 10:05 a.m., the maintenance supervisor was asked if they had any open work orders. The maintenance supervisor stated there were two work orders for air conditioners on e-wing and did not have any open work orders for anything else. On 09/04/2025 at 10:39 a.m., the administrator was shown the walls in room for Resident #9 and Resident #52. The administrator stated Resident #52 refused for days upon days to get out of the bed to make the repairs. The administrator stated the attempts to repair the wall in Resident #9's room were not documented. The administrator stated the damage to the wall in Resident #53's room was just forgotten. The administrator stated they do not have a policy for maintaining a safe home like environment. The administrator stated they did not have a maintenance person for over a month. The administrator stated the damaged walls did not reflect a homelike environment. 3. On 09/04/25 at 11:15 a.m., the following observations were made with HK #1 in the whirlpool bathroom on the A hall:a. a fan and fake plant hanging next to the whirlpool were covered in dust,b. green algae, hair, and soap scum were on the panel controls for the whirlpool bath,c. debris, a wet blanket, and a soiled glove was on the floor against the walls, d. soap scum, dust, and debris were on the shelves used to store supplies, ande. there was a missing access panel for the whirlpool bath with visible soiled floors and plumbing pipes covered in dust and debris behind the whirlpool bath. On 09/04/25 at 11:25 a.m., the following observations were made with HK #1 in the shower/bath on C hall:a. pink mold was observed on the floor in the corner;b. dust and debris were on the shower head and pipe overhead; and c. a plastic cabinet used to store shower supplies was open with shelves that were soiled with soap scum and debris. On 09/05/25 at 11:39 a.m., the following observations were made on the memory care whirlpool bathroom:a. there was an access panel for the whirlpool bathtub leaning against the wall with tape from a previous repair and not covering the whirlpool access;b. there was dirt, debris, hair ties, and resident hair on the floor around the perimeter; andc. a broom laying on the floor. Resident #29's quarterly assessment, dated 07/11/25, (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showed their cognition was intact with a BIMS score of 13. The assessment showed Resident #29 required partial to moderate assistance with showers and supervision or touching assistance for shower transfers. Resident #9s significant change assessment, dated 08/19/25, showed their cognition was moderately impaired with a BIMS score of 12. On 09/03/25 at 10:08 a.m., Resident #29 stated the bathrooms/showers were very dirty and needed to be cleaned. On 09/04/25 at 11:29 a.m., HK #1 was asked about the three bathrooms observed. HK#1 stated they were not responsible for cleaning the showers and the shower aide, CNA #1, was responsible for cleaning the showers. HK #1 stated the shower/bathrooms were not clean and sanitary. On 09/04/25 11:51 a.m., CNA #1 stated they were responsible for maintaining (cleaning) the showers on A hall and C hall. CNA #1 was shown the three bath/showers on hall A, hall C, and the memory care hall. CNA #1 stated they did not realize how dirty and dusty they were. CNA #1 stated they had not wiped the controls down in a few days and the whirlpool room on A hall needed to be deep cleaned. CNA #1 stated at the end of the day, they get tired and did not clean the bathrooms like they should be cleaned. On 09/04/25 at 12:25 p.m., the DON was shown the three shower/whirlpool baths on hall A, hall C, and the memory care halls. The DON stated the bath/showers used by residents were not clean and sanitary. 09/04/25 at 12:26 p.m., the administrator was shown the three shower/whirlpool baths on hall A, Hall C, and the memory care halls. The administrator stated the shower/baths were not clean, sanitary, and did not reflect a clean and sanitary homelike environment.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on record review and interview, the facility failed to have an effective quality assessment and assurance program that identified concerns and implemented actions to correct the concerns. The DON identified 53 residents resided in the facility. An undated policy provided by the facility titled Quality Assurance and Performance Improvement Program, read in part, The primary purpose of the Quality Assurance and Performance Improvement program is to establish data-driven, facility-wide processes that improve quality of care.On 09/05/25 at 11:55 a.m., the administrator was asked for quality assurance and performance improvement meeting documentation for the past year, from August 2024 thru August 2025.The administrator stated they did not have a book, or any documentation, for that time period. The administrator stated they had looked for it and had not been able to locate it. The administrator stated they had the meetings, but do not have any documentation available.

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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. Based on record review and interview, the facility failed to ensure a PRN psychotropic medication was limited to 14 days for 1 (#40) of 5 sampled residents reviewed for PRN psychotropic medications.The DON identified 53 residents resided in the facility and 41 were taking psychotropic medication.Findings:An undated policy titled Initiation of Psychotropic Drugs, read in part, PRN psychotropic medication orders are limited to 14 days.A Physician's Order, dated 07/23/25, read in part, Lorazepam (a psychotropic drug) oral tablet 0.5mg Give one tablet by mouth every 6 hours as needed for anxiety.A MAR for August 2025 showed Resident #40 was given Lorazepam 0.5mg two times on 08/09/25 and once on 08/14/25.On 09/05/25 at 12:20 p.m., the DON was asked what the policy was for PRN psychotropic medications. The DON stated, We have to have a stop date. They were asked what the stop date should b. They stated, 14 days. Resident #40's PRN Lorazepam order was shown to the DON and asked what the stop date was for the medication. They stated, [They] are on hospice, so we don't put stop dates on hospice residents. The DON was asked to read the facility's policy. The DON stated, I guess we should have a stop date on it. The DON was asked what the stop date should have been since the order was written on 07/23/25. They stated, August 6th.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, record review, and interview, the facility failed to accurately code MDS assessment for a resident's mobility device for 1 (#3) of 14 sampled residents reviewed for MDS accuracy The administrator identified 53 residents resided in the facility.Findings:On 09/03/25 at 9:13 a.m., Resident #3 was observed in a power wheelchair moving down the hall independently. On 9/05/25 at 10:36 a.m., Resident #3 was observed ambulating with power wheelchair in the hall independently. An admission record for Resident #3, dated 12/11/24, showed they were admitted with diagnoses which included cerebral infarction and spinal stenosis. A quarterly assessment for Resident #3, dated 06/26/25, showed their cognition was intact with a BIMS score of 15. The assessment showed in section GG0115, Resident #3 did not use any mobility devices. The assessment showed they were dependent for chair to bed transfers. The assessment showed Resident #3 was unable to walk. On 09/03/25 at 9:13 a.m., Resident #3 stated they used a power wheelchair to move around the facility. On 09/05/25 at 10:39 a.m., CMA #2 was asked how Resident #3 ambulated. CMA #2 stated Resident #3 used a power wheelchair to move around the facility. On 09/05/25 at 10:45 a.m., MDS coordinator #1 was asked how Resident #3 ambulated. MDS coordinator #1 stated Resident #3 did not walk and used a power wheelchair to move around the facility. MDS Coordinator #1 was asked what does Resident #3's quarterly assessment, dated 06/25/25, document in section GG on question GG0115. MDS Coordinator #1 stated the quarterly assessment, dated 06/25/25, did not document Resident #3 used a wheelchair. MDS Coordinator #1 was asked if the assessment was accurate. MDS coordinator #1 stated, No sir. MDS Coordinator #1 stated the assessment was miscoded. MDS Coordinator #1 stated the facility follows the RAI manual and did not have a policy on accurately coding assessments.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review, and interview, the facility to ensure a level II PASARR was completed after a new mental health diagnosis for 1 (#41) of 5 sampled residents reviewed for PASARR's.The administrator identified 53 residents resided in the facility. Findings:On 09/04/25 at 10:14 a.m., Resident #41 was observed in the resident council meeting. The resident was dressed and participating in discussions. Resident #41's PASARR level I, dated 09/09/22, showed Resident #41 did not have evidence, history, or a diagnosis of a serious mental illness. The electronic health record for Resident #41, dated 11/12/24, showed Resident #41 was diagnosed with unspecified psychosis not due to a substance or known physiological condition. An annual assessment for Resident #41, dated 07/25/25, showed their cognition was intact with a BIMS score of 15. The assessment showed they had diagnoses which included depression and psychotic disorder. The electronic health record for Resident #41 was reviewed. There was not a new PASARR level II completed after the new diagnosis on 11/12/24 of unspecified psychosis not due to a substance or known physiological condition. On 09/04/25 at 9:51 a.m., MDS coordinator #1 stated Resident #41 had a PASARR level I completed on 09/13/22. MDS Coordinator #1 stated Resident #41 had a new diagnosis of unspecified psychosis not due to a substance or known physiological condition on 11/12/24. MDS Coordinator #1 stated a PASARR level II was not completed after the new diagnosis of unspecified psychosis not due to a substance or known physiological condition. MDS Coordinator #1 stated a PASARR level II should have been completed after the new diagnosis on 11/12/24. On 09/04/25 at 9:55 a.m., the DON was asked about Resident #41's new diagnosis of unspecified psychosis not due to a substance or known physiological condition on 11/12/24 and the PASARR policy. The DON stated there should have been another PASARR completed because the resident had a new diagnosis of psychosis. The DON stated a PASARR level II was not completed after the new diagnosis on 11/12/24. The DON stated they did not have a policy on PASARRs.

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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. Based on observation, record review, and interview, the facility failed to ensure:a. an oxygen nasal cannula was placed in a bag when not in use to prevent infections for 1 (#29) of 20 sampled residents reviewed for infection control practices, andb. staff changed gloves while performing catheter care for 1 (#4) of 2 sampled residents reviewed for catheter care.The DON identified 20 residents received oxygen therapy and two residents had catheters. Findings:1.On 09/05/25 at 10:18 a.m., CNA #2 donned gloves and unfastened Resident #4's brief. CNA #2 removed one wet wipe from a package and used it to wipe Resident #4's peri-area front to back. CNA #2 repeated this process three times. CNA #2 then removed another wet wipe and cleaned Resident #4's catheter from their urinary meatus down the catheter tubing approximately five inches. On 09/05/25 at 10:21 a.m., CNA #2 and CNA #3 rolled Resident #2 to their left side. CNA #2 removed Resident #2's brief and disposed of it in the trash can. CNA #2 then used a clean wet wipe to cleanse Resident #2's buttocks. CNA #2 then tucked a clean brief under the resident. CNA #2 and CNA #3 rolled Resident #2 to their right side. CNA #3 pulled the clean brief under the resident and then rolled the resident to their back. CNA #2 and CNA #3 each fastened the brief. CNA #2 used the bed remote to raise Resident #4's head of bed and lower the bed back down to the lowest position. CNA #2 then moved the resident's bed back against wall. On 09/05/25 at 10:23 a.m., CNA #2 doffed their gown and gloves and disposed of both in the trash. CNA #2 utilized hand sanitizer. An undated policy titled Catheter Care, Urinary, read in part, Maintain clean technique and isolation precautions as indicated. On 09/05/25 at 10:25 a.m., CNA #2 was asked how many times they changed their gloves during catheter care. They stated, I didn't. I forgot about that. They were asked when they should have changed their gloves. CNA #2 stated, After I cleaned [Resident #2] the first time, before placing the clean brief under [them]. 2.On 09/03/25 at 10:15 a.m., Resident #29's room, was observed to have an oxygen concentrator with the oxygen tubing and a nasal cannula coiled up on top of the concentrator. The nasal cannula was not in a bag. On 09/04/25 at 7:00 a.m., Resident #29s room was observed to have an oxygen concentrator with the oxygen tubing rolled up with a nasal cannula laying on top of the concentrator. The nasal cannula was not in a bag to prevent infections. An admission record for Resident #29's, dated 03/28/25, showed they were admitted with diagnoses which included encounter for orthopedic fracture and dementia. A physician order for Resident # 29's, dated 06/17/25, read in part, Oxygen: Continuous at 4L/min via N/C. A care plan for Resident # 29's, dated 06/17/25, read in part, Oxygen: Continuous at 4L/min via N/C at bedtime for SOB [shortness of breath] while sleeping. A quarterly assessment for Resident #29's, dated 07/11/25, showed their cognition was intact with a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	BIMS score of 13. The assessment showed Resident #29 was receiving oxygen therapy. On 09/03/25 at 10:15 a.m., Resident #29 stated they wear oxygen every night at bedtime. On 09/04/25 at 7:18 a.m., CMA #1 stated Resident #29 wears oxygen every night and they take it off in the morning. CMA #1 stated, When I take it off, I roll up the tubing and the nasal cannula and put in on the concentrator handle rolled up. On 09/04/25 at 7:30 a.m., the infection preventionist stated all oxygen tubing and nasal cannulas should be bagged when not in in use. The infection preventionist was shown the oxygen tubing and nasal cannula rolled up on the oxygen concentrator and placed under the handle. The infection preventionist stated the tubing and nasal cannula was not in a bag and was laying on top of the oxygen concentrator which could cause infection. The infection preventionist stated they did not have a policy on bagging the nasal cannula when not in use to prevent infections. 09/04/25 at 7:31 a.m., the DON was shown the oxygen concentrator and tubing. The DON stated the tubing and nasal cannula was not in a bag and was rolled up on top of the oxygen concentrator.