STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445210	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntingdon Health & Rehabilitation Center	635 High Street Huntingdon, TN 38344

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation, and interview, the facility failed to provide care and services for residents with percutaneous endoscopic gastrostomy (PEG) tubes (a plastic tube inserted into the stomach to administer medications, supplements and liquid food) when staff failed to ensure the enteral feeding (liquid nourishment) and the flush solution (water used to flush the peg tube) were replaced in a timely manner and properly labeled for 1 of 2 (Resident #28) sampled residents reviewed for enteral feedings. The findings include: 1. Review of the facility policy titled, Feeding Tubes, dated 10/15/2024, revealed .Feeding tubes will be maintained in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible . 2. Review of the medical record revealed Resident #28 was admitted to the facility on [DATE], with diagnoses including Gastrostomy Status, Diabetes, Seizures, and Dementia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #28 was rarely/never understood and required the use of a feeding tube. Review of the Physician's Orders dated 11/18/2025, revealed .Enteral Feed Order every shift for enteral feeding related to GASTROSTOMY STATUS.Jevity 1.5 40/hr [hour] q [every] 22 hours . Review of the Physician's Orders dated 12/17/2025, revealed .Enteral Feed Order every shift for Peg Tube Feedings 50 ml/hr [milliliters] H2O [water]. Observation in Resident #28's room on 1/5/2026 at 10:49 AM, 11:47 AM, and 2:27 PM, revealed water in a clear bag infusing per feeding pump dated 1/3/2026. Observation in Resident #28's room on 1/6/2026 at 7:35 AM, 11:05 AM, and 1:25 PM, revealed Jevity 1.5 tube feeding dated 1/5/2026 at 8:00 AM, infusing per feeding tube pump and a clear bag of fluids with H2O on bag without a label, date or time. During an interview on 1/6/2026 at 1:25 PM, the Director of Nursing (DON) was asked who is responsible for changing the tube feeding bottles, tubing, and water. The DON stated, I would have to look at the policy to be sure, but I want to say it is the night shift. The DON was asked should tube feedings and water be hung and infusing for more than 24 hours. The DON stated, No, Ma'am. The DON was asked should all tube feedings and water be labeled and dated. The DON stated, Yes.

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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(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** Based on policy review, medical record review, observation, and interview, the facility failed to obtain and follow Physician's Orders for the use of oxygen for 2 of 3 (Resident #42 and #62) sampled residents reviewed for respiratory care. The findings include: 1.Review of the facility policy titled, Oxygen Administration, dated 6/23/2025, revealed .Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences.Oxygen is administered under orders of a physician.Infection control measures include.Change oxygen tubing and mask/cannula weekly and as needed. 2. Review of the medical record revealed Resident #42 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Interstitial Pulmonary Disease, Atrial Fibrillation, and Dependence on Supplemental Oxygen.? ? Review of the Physician's Order dated 4/3/2025, revealed .Oxygen: RUN @ [at] [2]L/MIN [liter/min] VIA [by way of.N/C [nasal cannula] .CONTINUOUS every shift Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #42 scored a 3 on the Brief Interview for Mental Status (BIMS) assessment, which indicated Resident #42 was severely cognitively impaired. Resident #42 was not coded as receiving oxygen therapy. ? ?Review of the Physician's Orders dated December 2025 and January 2026, revealed there was no order for the oxygen tubing/cannula to be changed. Review of the Medication Administration Record (MAR) dated December 2025 and January 2026, revealed Resident #42 was administered Oxygen therapy via nasal cannula at 2 liters per minute daily. Review of the MAR and Treatment Administration Record (TAR) dated December 2025 and January 2026, revealed there was no documentation of oxygen tubing/cannula changes. Observation in Resident #42's room on 1/5/2026 at 9:59 AM and 1:51 PM, revealed the Resident was receiving oxygen via nasal cannula with the oxygen concentrator set at 3.5 liters per minute and the oxygen tubing/cannula was not dated. During an observation and interview in Resident #42's room on 1/5/2026 at 4:19 PM, Licensed Practical Nurse (LPN) A confirmed the oxygen concentrator was set at 3.5 liters per minute and the ordered rate was 2 liters per minute. LPN A was asked should the oxygen concentrator be set at the prescribed rate. LPN A stated Yes.? 3. Review of the medical record revealed Resident #62 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including Dementia, Heart Disease, Heart Failure, Hyperlipidemia, and Hypertension. Review of the Weights and Vitals Summary sheet revealed Resident #62 received oxygen therapy via [by way of] Nasal Cannula on the following dates between the dates of 7/10/2025-12/18/2025: 7/10/2025, 8/30/2025, 8/31/2025, 9/1/2025, 9/3/2025, 9/5/2025, 9/6/2025, 9/27/2025, 9/28/2025, and 12/18/2025. Review of the quarterly MDS assessment dated [DATE], revealed Resident #62 scored a 4 on the BIMS assessment, which indicated he was severely cognitively impaired and was not coded as receiving oxygen therapy. Review of the Physician's Orders dated 9/2025 revealed no order for oxygen therapy. Review of the Skilled Daily note dated 9/27/2025 at 10:35 PM and 9/28/2025 at 7:13 PM, revealed .Most Recent O2 [Oxygen] sats.Method.Oxygen via Nasal [cannula]. Review of the quarterly MDS assessment dated [DATE], revealed Resident #62 scored a 4 on the BIMS assessment, which indicated he was severely cognitively impaired and was not ceded as receiving oxygen therapy. Review of the Care Plan dated 12/29/2025, revealed Oxygen therapy was not included in the care plan for Resident #62. Review of the Nursing Quarterly note dated 12/30/2025 at 3:44 PM, revealed .Most Recent O2 sats.Method.Oxygen via Nasal [cannula]. Review of the Physician's Orders dated 12/2025, revealed no order for oxygen therapy. Observations in Resident #62's room on 1/5/2026 at 9:07 AM,1:47 PM, and 4:06 PM, and on 1/6/2026 at 8:07 AM and 1:04 PM, revealed Resident #62 was receiving oxygen therapy at 2.5 L/min via nasal cannula. During an interview on 1/6/2026 at 1:12 PM, Registered Nurse (RN) B was (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	asked what the Physician's order was for Resident #62's oxygen therapy. RN B stated, 2 liters. RN B was asked how long Resident #62 had been receiving oxygen therapy. RN B stated .as far back as I can remember.I think as far back as July [2025]. During an observation and interview on 1/6/2026 at 1:16 PM, RN B was asked what Resident #62's oxygen concentrator was set at. RN B stated, Looks like it's on 2.25 liters. Review of the Physician's Orders dated 1/7/2026, revealed .Oxygen: RUN @ [at] 2 L/min [Liters per minute] as needed. Observation in Resident #62's room on 1/7/2026 at 9:59 AM revealed Resident #62 receiving oxygen therapy with the concentrator set between 2 and 2.5 L/min via nasal cannula. The facility failed to follow Physician's orders for the use of oxygen at 2L/min. During an interview on 1/7/2026 at 1:20 PM, the DON was asked to explain how oxygen therapy should be administered. The DON stated, .follow the orders.by the rate and route in the order. The DON was asked if oxygen should be administered without an order. The DON replied .They should not give it if there is not an order. During an interview on 1/7/2026 at 3:14 PM, the Director of Nursing (DON) was asked if residents that receive oxygen therapy should have an order for the oxygen tubing/cannula to be changed. The DON stated Yes. The DON was asked if oxygen therapy should be administered at the prescribed rate. The DON stated Yes.