STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445218	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cordova Wellness and Rehabilitation Center	955 Germantown Pkwy Cordova, TN 38018

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, and interview, the facility failed to complete an accurate Minimum Data Set (MDS) assessment for 3 of 33 (Resident #3, #147 and #181) residents reviewed for MDS discrepancies. The findings include: 1. Review of the facility's policy titled, RAI (Resident Assessment Instrument) -MDS 3.0 Completion, dated 1/1/2023, revealed .Residents are assessed using a comprehensive assessment process, in order to identify care needs . 2. Review of the medical record revealed Resident #3 was admitted to the facility on [DATE], with diagnoses including Encephalopathy, Osteoarthritis, Schizoaffective Disorder, and Hypothyroidism. Review of the quarterly MDS assessment dated [DATE], revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. The MDS section O0110 was inaccurately coded to reflect Resident #3 received dialysis. Review of the Physician Orders dated 3/11/2026, revealed Resident #3 did not have an order for dialysis. During an interview on 4/15/2026 at 8:47 AM, the MDS Coordinator was asked if the quarterly MDS for Resident #3 should have been coded for dialysis. The MDS Coordinator stated, .It is not ordered and definitely should not have been on the MDS . 3. Review of the medical record revealed Resident #147 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Chronic Kidney Disease, Convulsions, Dementia, and Insomnia. Review of the Order Review History Report dated 3/15/2026-4/15/2026 revealed Resident #147 had an order dated 3/5/2026 to check wander guard function every day beginning 3/7/2026. Review of the quarterly MDS assessment dated [DATE], revealed Resident #147 scored a 6 on the BIMS assessment, which indicated she was severely cognitively impaired, and a wander/elopement alarm was not used. During an interview on 4/15/2026 at 8:47 AM, the MDS Coordinator was asked should the quarterly MDS for Resident #147 have been coded for a wander guard. The MDS Coordinator stated, .no, but it should be . During an interview on 4/15/2026 at 8:54 AM, the Director of Nursing (DON) confirmed that Resident #147 should have been coded for a wander guard. 4. Review of the medical record revealed Resident #181 was admitted to the facility on [DATE], with diagnoses including Cerebral Infraction, Gastrostomy, Aphasia, and Dysphagia. Review of the quarterly MDS assessment dated [DATE], revealed Resident #181 score a 00 on the BIMS assessment, which indicated she was severely cognitively impaired. Resident #181 was not coded for receiving nutrition by a tube feeding (a flexible plastic tube that supplies nutrition and fluids into the stomach of someone who cannot chew or swallow safely). Observation in the resident's room on 4/14/2026 at 7:41 AM, revealed Resident #181 was receiving an enteral (delivery of nutrition directly into the stomach) feeding of Jevity 1.5 (a high calorie liquid supplement for tube feeding) and a water flush running at a rate of 85 ml (milliliters) per hour through a feeding tube. During an interview on 4/15/2026 at 10:31 AM, the MDS Coordinator was asked if Resident #181 was coded for enteral feeding on the 1/29/2026 MDS. The MDS Coordinator stated, Enteral feeding is not coded. The MDS Coordinator was asked should Resident #181 have been coded for enteral feeding on the 1/29/2026 MDS. The MDS Coordinator 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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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 facility policy review, medical record review, observation, and interview, the facility failed to maintain emergency supplies at the bedside for 1 of 1 (Resident #11) sampled residents reviewed for tracheostomy (a surgically created opening in the neck to help with breathing) care. The findings include: 1. Review of the undated facility policy titled, Tracheostomy Care, Disposable Cannula [a small tube that is inserted into an open area of the body] revealed .The facility will ensure that residents who need respiratory care, including tracheostomy care and tracheal suctioning, is provided such care consistent with professional standards of practice, the comprehensive person-centered care plan and resident goals and preferences.Maintain a suction machine, a supply of suction catheters, correctly sized cannulas, and an ambu bag [a hand held device used to deliver air or oxygen to the lungs through a self-inflating bag in order support or replace breathing during an emergency] easily accessible for immediate emergency care . 2. Review of medical record revealed Resident #11 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Tracheostomy, and Gastrostomy. Review of the quarterly Minimum Data Set assessment dated [DATE], revealed Resident #11 scored a 00 on the Brief Interview for Mental Status assessment, which indicated he was severely cognitively impaired. Resident was dependent on staff for all activities of daily living (ADLs). Resident #11 received tracheostomy care. Review of the Physician's Orders dated 8/27/2025, revealed the following:a. Respiratory Therapist: change .trach every month . b. Perform trach [tracheostomy] and oral care every shift and as needed every shift .c. Change trach disposable inner cannula daily and as needed every day shift AND as neededd. May suction trach and mouth .every shift AND as needed Observation in Resident #11's room on 4/13/2026 at 4:02 PM, revealed there was no ambu bag in the resident's room. Licensed Practical Nurse (LPN) F was asked does the resident need an ambu bag. LPN F stated, Yes, obviously he does not have one. It should be .in the room and kept close to the bed. During an interview on 4/15/2026 at 2:58 PM, the Director of Nursing (DON) was asked where should the resident's ambu bag be kept. The DON stated, The ambu bag should be within close proximity. If an emergency, it should be available in the room for easy access.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation, and interview, the facility failed to ensure that an account of all controlled medications was accurately reconciled for 1 of 10 medication carts (700 Hall Medication Cart #4). The findings include: 1. Review of the undated facility policy titled, Medication Administration, revealed .If medication is a controlled substance, sign the narcotic book .Correct any discrepancies and report to nurse manager . 2. Review of the medical record revealed Resident #43 was admitted to the facility on [DATE], with diagnoses including Traumatic Brain Injury, Paralytic Syndrome, Diabetes, and Anxiety. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #43 scored a 12 on the Brief Interview for Mental Status (BIMS) assessment, which indicated she was moderately cognitively impaired. Review of the Physician's Orders dated 5/15/2025, revealed .Gabapentin [used for pain]100 MG [milligram] .Give 1 capsule by mouth three times a day . Review of the Physician's Orders dated 3/18/2026, revealed .Eszopiclone [for sleep] Tablet 1 MG .Give 1 tablet by mouth at bedtime for Insomnia . Review of the document titled, Controlled Drug Receipt/Record/Disposition Form, revealed .GABAPENTIN CAP [capsule] 100MG .GIVE 1 CAPSULE BY MOUTH THREE TIMES DAILY .Date 4/14/26 .Left 27 . Review of the document titled, Controlled Drug Receipt/Record/Disposition Form, revealed .ESZOPICLONE TAB [tablet] 1MG .Date 4/15 [4/15/2026] .Time 6 A [AM] .Left 3 . During an observation and interview at medication cart #4, in the 700 Hallway on 4/15/2026 at 7:58 AM, Licensed Practical Nurse (LPN) E was asked how many capsules of Gabapentin 100 mg were left in the med cart for Resident #43. LPN E stated, 26. LPN E confirmed there were only 26 Gabapentin 100 mg capsules left on the narcotic card in the drawer of the medication cart. The Controlled Drug Receipt/Record/Disposition Form for Resident #43's Gabapentin read that there were 27 capsules left. LPN E confirmed the count on the form did not match the number of capsules in the drawer. Registered Nurse (RN) D was standing by the medication cart and overheard the incorrect count. RN D stated that she (RN D) was working the previous shift and must have charted the administration of the medication on the wrong log because she (RN D) had administered the medication this morning. LPN E confirmed there were 4 Eszopiclone 1 mg tablets in the narcotic card in the drawer of the medication cart. The Controlled Drug Receipt/Record/Disposition Form for Resident #43's Eszopiclone 1 MG showed 3 pills left. RN D and LPN E determined that RN D had charted the administration of the Gabapentin 100 mg on Resident #43's Controlled Drug Receipt/Record/Disposition Form for Eszopiclone 1 MG, resulting in there being 1 to many Eszopiclone and 1 to few Gabapentin for Resident #43 and the count of both medications to be incorrect. RN D and LPN E were asked if they had completed a narcotics reconciliation at hand-off (shift change), to which they both stated yes. RN D also stated that when they were counting at hand-off that she (RN D) must have given LPN E the wrong number. During an Interview on 4/15/2026 at 3:37 PM, the Director of Nursing (DON) was asked if the nurses were expected to complete a narcotic count at shift change. The DON stated, Yes. The DON was then asked if she expected a narcotic count to be correct after the count at shift change. The DON stated, Yes. The DON was also asked if she expected the two nurses counting to find a discrepancy in the narcotic count if it was incorrect during the count at shift change. The DON stated, .Yes .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation, and interview, the facility failed to maintain and ensure the prevention and spread of infection when 4 of 8 (the Infection Preventionist Licensed Practical Nurse (LPN) A and B, and Registered Nurse (RN) C) staff failed to use Personal Protective Equipment (PPE) during wound care, failed to use proper hand hygiene, and failed to clean reusable equipment between residents. The findings include: 1. Review of the undated facility policy titled, Medication Administration, revealed .Medications are administered by licensed nurses, or other staff who are legally authorized to do so .in a manner to prevent contamination of infection .Wash hands prior to administering medication per facility protocol and product . Review of the undated facility policy titled, Hand Hygiene, revealed .All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility .Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR) .If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves .Between resident contacts .Before applying and after removing personal protective equipment (PPE), including gloves .Before performing resident care procedures . Review of the undated facility policy titled, Cleaning and Disinfecting of Resident-Care Equipment, revealed .Resident-care equipment can be a source of indirect transmission of pathogens. Reusable resident-care equipment will be cleaned and disinfected in accordance with CDC [Centers for Disease Control and Prevention] recommendations in order to break the chain of infection .Reusable multiple-resident items are items that may be used multiple times for multiple residents. Examples include stethoscopes, blood pressure cuffs .come in contact with intact skin, but not mucous membranes. These items require cleaning and low/intermittent level disinfection .use of EPA [Environmental Protection Agency]-registered disinfectants) .Staff shall follow established infection control principles for cleaning and disinfecting reusable, non-critical equipment .Each user is responsible for routine cleaning and disinfection of multi-resident items after each use, particularly before use for another resident .Multiple-resident use equipment shall be cleaned and disinfected after each use . Review of the undated facility policy titled, Enhanced Barrier Precautions, revealed .Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted Gown and gloves use during high contact resident care activities.An order for enhanced barrier precautions will be obtained for residents with any of the following.wounds, indwelling medical devices.urinary catheters [tubing in the bladder], feeding tubes [tube placed into your stomach or bowel to help you get nutrition], tracheostomy [opening that allows air into the lungs].High contact resident care activities include.dressing.transferring.changing linens.Device care or use .urinary catheters, feeding tubes, tracheostomy .wound care. 2. Review of medical record revealed Resident #11 was admitted on [DATE], with diagnoses (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	including Respiratory Failure, Tracheostomy, Gastrostomy, and Myocardial Infarction, Contracture of Feet, Peripheral Vascular Disease, and Cerebral Infarction. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #11 scored a 00 on the Brief Interview for Mental Status (BIMS) assessment, which indicated he was severely cognitively impaired. Review of the Physician Order dated 8/27/2025, revealed Resident #11 had an order for Enhanced Barrier Precautions. Review of the Order Summary Report dated 4/8/2026, revealed Resident #11 had an order for a stage 3 pressure ulcer to the back of the neck, to clean with Normal saline, pat dry with gauze, skin prep (applied to skin before a bandage to protect from skin breakdown) to peri wound (area around a wound), calcium alginate (used to reduce the risk of infection and to absorb drainage) with silver alginate (helps remove unwanted tissue) to wound bed (open area of the wound), cover with an island border gauze (an adhesive pad used to cover wounds), to do every day and as needed and to monitor for sign and symptoms of infection. Review of the facility's Weekly Wound Progress report dated 4/13/2026 at 3:05 PM, revealed Resident #11 had a pressure ulcer at the posterior neck (back of the neck). During a random observation and interview in Resident #11's room on 4/13/2026 at 4:36 PM, the ICP and LPN A were touching the resident at the neck area with no gown or gloves on. The ICP and LPN A were asked about the care provided. The ICP stated .We are doing wound care . The ICP was asked if they should both have had on a gown and gloves. The ICP stated, Yes. During an interview on 4/15/2026 at 3:02 PM, the Director of Nursing (DON) was asked what should staff wear when providing care for a resident with a wound. The DON stated, They should wear a gown and gloves. 3. Review of the medical record revealed Resident #145 was admitted on [DATE] and then readmitted on [DATE], with diagnoses including Chronic Diastolic Heart Failure, Chronic Kidney Disease, and Diabetes Mellitus. Review of the admission MDS dated [DATE], revealed Resident #145 score a 15 on the BIMS assessment, which indicated she was cognitively intact. Observation during med administration in the 300 hallway on 4/14/2026 at 4:52 PM, revealed LPN B sanitized her hands and gathered supplies for Resident #145. She then knocked and entered Resident #145's room and placed blood glucose monitoring supplies on a barrier on the resident nightstand. LPN B washed her hands with soap and water and put on clean gloves. LPN B placed a glucometer (instrument for measuring blood sugar) strip in the glucometer, cleaned Resident #145's finger with an alcohol pad, pricked the finger with a lancet, and applied a blood sample to the strip. The glucometer gave a reading of 275. LPN B disposed of the lancet in the sharps box, removed her gloves, and washed her hands. LPN B exited the room, placed a barrier on the medication cart and placed the used glucometer on the barrier. LPN B walked back into Resident #145's room to get gloves. LPN B returned to cart, put on clean gloves without performing hand hygiene, obtained an insulin pen (medication used to help lower blood sugar) pen, and prepared then ordered amount of medication. LPN B removed her gloves and entered the resident's room with the medication and an alcohol pad. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN B placed the insulin pen on a barrier, washed her hands, put on gloves, and administered the medication to Resident #145. LPN B failed to perform hand hygiene between handling a used glucometer and putting on gloves to prepare medication for Resident #145. 4. Review of the medical record revealed Resident #155 was admitted to the facility on [DATE], with diagnoses including Osteoporosis, Dementia, and Repeated Falls. Review of the quarterly MDS assessment dated [DATE], revealed Resident #155 scored a 4 on the BIMS assessment, which indicated she was severely cognitively impaired. 5. Review of the medical record revealed Resident #193 was admitted to the facility on [DATE], with diagnoses including Dementia, Depression, Anxiety Disorder, and Psychosis. Review of the admission MDS dated [DATE], revealed Resident #193's admission MDS was ongoing. Observation during med administration in the 600 hallway on 4/15/2026 at 9:30 AM, revealed RN C picked up the blood pressure cuff, knocked on Resident #155's door, and entered the resident's room. RN C placed the blood pressure cuff on Resident 155's left arm and obtained the blood pressure. RN C exited Resident #155's room and placed the blood pressure cuff on the med cart. RN C performed hand hygiene with hand sanitizer and prepared medications for Resident #155. RN C knocked on the door, entered the resident's room, administered Resident #155's medications, and exited the Resident's room, without performing hand hygiene. RN C signed off on Resident #155's medications. RN C gathered the previously used blood pressure cuff, entered Resident #193's room without performing hand hygiene and without cleaning the blood pressure cuff. RN C obtained a Blood Pressure reading on Resident 193 and exited the room, placing the blood pressure cuff on the side of the medication cart. RN C began preparing medications for Resident #193. RN C knocked on the door and entered the room without performing hand hygiene, administered medications to Resident #193 and exited the Resident's room. RN C failed to clean reusable equipment (blood pressure cuff) and failed to perform hand hygiene prior to administering medications and between care of residents. During an interview on 4/15/2026 at 9:43 AM, RN C was asked if she should have used some form of hand hygiene before moving on to the next resident. RN C stated, Yes. RN C was then asked, when should you practice hand hygiene. RN C stated, When entering and leaving resident rooms and after care with resident and when putting on and taking off gloves. RN C was also asked if she should have cleaned the blood pressure cuff between residents. RN C stated, Yes. During an interview on 4/15/2026 at 3:37 PM, the DON was asked if she expected staff to practice hand hygiene between glove changes and when moving between one resident's care to another. The DON stated, .Yes .either with soap and water if hands are soiled or hand sanitizer . The DON was then asked if the facility staff should clean equipment such as blood pressure cuffs, between residents. The DON stated, Yes.