STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375110	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bartlesville Health and Rehabilitation Community	3434 Kentucky Place Bartlesville, OK 74006

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 42171 Based on record review and interview, the facility failed to ensure a resident's representative was notified of a fall for one (#57) of one resident reviewed for notification of changes. The DON reported the facility census was 71. Findings: A facility policy titled Family Notification Policy, updated 01/2024, read in part, The facility should identify a primary contact person or POA to receive notification .Required notifications .Accidents or any injury including falls. Resident #57 had diagnoses which included dementia and weakness. A late entry nurse note, dated 09/13/24, documented Resident #57 had fallen. The note did not document the resident's representative had been contacted. On 12/04/24 at 9:37 am, LPN #1 stated they had spoken with Resident #57's representative on 09/18/24 and the representative was unaware the resident had fallen on 09/13/24. LPN #1 also stated that family should always be notified after a fall. On 12/04/24 at 1:19 p.m., the DON stated the family should have been notified of Resident #57's fall on 09/13/24.

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 34270 Based on record review and interview, the facility failed to ensure the medical director and/or their representative participated in care plan development for one (#45) of 18 sampled residents whose care plans were reviewed. A Facility Listing Report, dated 12/02/24, documented 71 residents resided at the facility. Findings: A facility policy and procedure titled Policy and Procedure: Care Plans for Resident Care, dated 11/06/24, read in part, A comprehensive care plan will be developed within 7 days after the MDS has been completed. It should include measurable objectives and time frames to meet the resident's medical, nursing, mental and psychosocial needs that are identified during the MDS process. All interdisciplinary team members will help prepare this and review and revise it quarterly if a change in condition is noted. A quarterly resident assessment, dated 09/25/24, documented Resident #45's cognition was intact. A facility document titled Care Plan Conference Summary, dated 09/26/24, documented the individuals who attended the care plan meeting. The documented attendees did not include the medical director and/or their representative. The document did not include any documentation the medical director and/or their representative had reviewed the results of the meeting. On 12/02/24 at 1:36 p.m., Resident #45 stated they were not sure if they had gone to a care plan meeting. On 12/03/24 at 11:22 a.m., MDS coordinator #1 stated they were responsible for planning the resident care plan meetings. They stated all members of the interdisciplinary team were contacted for Resident #45's meeting on 09/26/24. They stated the physician had been notified of that meeting, but had not attended. They stated the physician had not been given the results of that meeting to review. They stated they usually do not involve the medical director unless they required an order for something that came up in the meeting. On 12/04/24 at 1:14 p.m., the DON stated the physician should participate in care planning for each resident and review the care plans.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 42171 Based on record review and interview, the facility failed to monitor a resident after a fall for one (#57) of one resident reviewed for falls. The DON reported the facility census was 71. Findings: A facility policy titled Fall Policy and Procedures, updated 11/06/24, read in part, If a fall does occur .Assess resident .Neuro checks as necessary .Provide treatment/immediate nursing interventions as needed .Notify the family .Notify the DON/ADON .Provide continuous documentation as follows: Observed fall without head injury V/S every shift x 24 hours. Unobserved fall without head injury V/S with neuro checks every shift X 48 hours .All falls must be documented on every shift for 72 hours along with the intervention and how it is working. Resident #57 had diagnoses which included dementia and weakness. A late entry nurse note, dated 09/13/24, documented Resident #57 had fallen. The note did not document the resident's representative or the DON/ADON had been notified. It did not document if the fall was witnessed or unwitnessed. The note did not document neuro checks had been initiated. No additional post-fall documentation was located in Resident #57's health record. On 12/04/24 at 9:37 a.m., LPN #1 stated after a fall a complete assessment should be completed, the physician, family and DON should be notified, and if the fall was unwitnessed by staff or the resident had a head injury that neuro checks should be implemented immediately. The LPN also stated the resident should be on priority charting for three days after the fall. On 12/04/24 at 1:19 p.m., the DON stated they did not know if the fall was witnessed or unwitnessed. They also stated facility policy had not been followed after Resident #57's fall on 09/13/24.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34270 Based on record review and interview, the facility failed to ensure pre and post dialysis patient assessments were filled out completely and routinely by staff for one (#45) of one sampled resident reviewed for dialysis care. The DON identified one resident at the facility received dialysis services. Findings: The facility was unable to provide a policy for the care of residents that received dialysis services. An admission record for Resident #45 documented they had been readmitted to the facility on [DATE]. It further documented Resident #45 had diagnoses which included stage five chronic kidney disease and dependence on renal dialysis. A quarterly resident assessment, dated 09/25/24, documented Resident #45's cognition was intact. On 12/02/24 at 1:24 p.m., Resident #45 stated the nursing staff had not been doing their vitals as they were supposed to related to their dialysis care. On 12/03/24 at 9:46 a.m., LPN #2 stated there was a binder at the nurse station that held the dialysis assessment forms. They stated there was not pre and post dialysis assessment documentation for each treatment Resident #45 had received. They stated the resident was scheduled to have dialysis treatments three times weekly. A review of the binder found it contained 14 documents titled, Dialysis Communication, dated on and between 09/19/24 and 11/27/24. Of those documents, five were partially filled out, missing the return assessment data. A review of the resident medical record found the resident was documented as having been assessed on 14 of 28 days they had received dialysis. On 12/04/24 at 1:14 p.m., the DON stated they had been unaware the dialysis assessments had not been filled out and would retrain nursing staff on those procedures.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 42171 Based on record review and interview, the facility failed to ensure an antianxiety medication was not prescribed on an as needed basis without a 14-day limit or a physician's explanation why it should be used beyond 14 days for one (#69) of five residents reviewed for unnecessary medications. The ADON reported 29 residents at the facility were prescribed psychotropic medications. Findings: A facility policy titled Antipsychotic P&P, dated 09/2014, read in part, Residents who receive antipsychotic, sedative, hypnotic, antidepressant, or any other medications prescribed to modify behavior are evaluated to determine the effectiveness of the medication for the identified problems .The use of antipsychotics should include .Use of the medication only for the duration needed, and at the lowest effective dose. Resident #69 had diagnoses which included anxiety disorder and depression. A physician order, dated 11/13/24, documented the resident was to receive alprazolam (an antianxiety medication) 0.25mg every 8 hours as needed. The physician's order did not have a stop date. A review of Resident #69's medical record did not document a rationale from the physician as to why the PRN order did not have a stop date of 14 days. On 12/04/24 at 9:06 a.m., the DON stated no rationale from the physician had been located. They also stated PRN psychotropic medications should be limited to 14 days without a rationale from the physician.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46703 Based on observation and interview, the facility failed to ensure dietary staff wore hair nets and beard guards while preparing food for the residents. The administrator identified 74 residents routinely ate meals provided by the facility kitchen. Findings: On 12/02/24 at 8:05 a.m., cook #1 was observed preparing food without wearing a hair net or beard guard. On 12/02/24 at 8:10 a.m., cook #1 stated they should be wearing a hair net and beard guard and that the facility was out of beard guards until the truck came in. On 12/02/24 at 8:30 a.m., the dietary manager stated the dietary staff should be wearing hair nets and beard guards. On 12/03/24 at 3:08 p.m., the administrator stated dietary staff should be wearing hair nets and beard guards.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 34270 Based on observation, record review, and interview, the facility failed to ensure: a. a licensed practical nurse cleaned their hands during wound care and catheter care for one (#16) of two sampled residents reviewed for wound care and catheter care; and b. failed to maintain a water management program to prevent the growth of Legionella and other opportunistic waterborne pathogens in the building water system. A resident matrix provided by the administrator documented seven residents had indwelling catheters. The DON stated 71 residents resided in the facility. Findings: A facility policy titled Water Management, dated 01/23, read in part, It is the policy of the facility to have a plan to reduce the risk of growth and spread of opportunistic pathogens including Legionnaires in the building water system .Procedure .Create the water management team .Identify and document the building description .Identify control measures .Document collection and transport methods. A facility policy titled Hand Hygiene, dated 01/31/24, read in part, Appropriate hand hygiene is essential in preventing transmission of infectious agents. 1. A physician's order, dated 03/29/24, documented Resident #16 was to receive care for their suprapubic urinary catheter daily on the day shift. On 12/02/24 at 12:57 p.m., Resident #16 stated they had been hospitalized multiple times for urinary tract infections. They stated they did have a suprapubic catheter at that time. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/04/24 at 9:30 a.m., LPN #3 was observed providing catheter care to Resident #16. LPN #3 was observed entering the resident's room and putting on gloves. LPN #3 was observed to uncover the resident then don gloves. They were observed cleaning the right posterior thigh with normal saline and a gauze. They discarded the dirty gauze and obtained a new gauze and dried the area. They discarded the gauze that gauze and picked up and applied xeroform to the wound. They then picked up a dressing and applied it to the wound. During the wound care portion of the care LPN #3 did not clean their hands or change gloves. LPN #3 then change their gloves. They then assisted the resident to roll onto their back. LPN #3 picked up gauze with a cleaning solution and cleaned around the area where the tubing entered the resident. They changed gloves. They dried the area they cleaned. They changed gloves. They then placed a section of gauze that had been slit and applied it around the catheter tubing. The LPN then threw away the last pair of gloves. LPN #3 did not clean their hands at any time during the wound and catheter care. Outside of the resident's room immediately following the care, LPN #3 was asked how they thought the care had gone. They stated they believed it went well. They were asked how many times they had changed their gloves during the care. They replied five or six times. They were asked how many times they cleaned their hands. They stated the had not cleaned their hands and had forgotten to do so. They stated they knew to clean their hands. On 12/04/24 at 1:14 p.m., the DON stated LPN #3 had made an error when the did not clean their hands between dirty and clean steps of providing care. They stated the staff get regular training in infection control, but they would go over it again with them. 2. On 12/04/24 at 11:45 a.m.,the maintenance supervisor stated they had a water management policy in place, but had not started monitoring yet.