

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  375124	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/08/2025
NAME OF PROVIDER OR SUPPLIER  Sequoyah Pointe Skilled Nursing and Therapy		STREET ADDRESS, CITY, STATE, ZIP CODE 614 E Cherrie Street Tahlequah, OK 74465	

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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>41318</p> <p>Based on observation, record review, and interview, the facility failed to ensure a call light was in reach for one (#35) of 24 sampled residents observed for call lights.</p> <p>The administrator identified 54 residents resided in the facility.</p> <p>Findings:</p> <p>Resident #35 had diagnoses which included chronic pain.</p> <p>The Care Plan, dated 09/28/22, documented to place call light within reach and to encourage the resident to use it.</p> <p>A Quarterly Assessment, dated 12/31/24, documented Resident #35's cognition was severely impaired. It documented the resident required assistance from staff for their ADLs and mobility.</p> <p>On 01/06/25 at 12:50 p.m., Resident #35 was observed laying in bed in their room. Resident #35 was heard screaming out wanting clean clothes. The call light was observed clipped to the privacy curtain out of reach of the resident. An orange sign was observed on the wall next to the resident's window. The sign read, Before leaving residents room please ensure all call light button are within residents reach. CNA #2 was observed going into Resident #35's room to provide care.</p> <p>On 01/06/25 at 12:53 p.m., CNA #2 stated Resident #35 was blind, but was able to use their call light if staff put it in the resident's hand.</p> <p>On 01/06/25 at 1:05 p.m., CNA #2 confirmed the call light had not been in reach.</p> <p>On 01/06/25 at 2:06 p.m., Resident #35 was observed laying in bed. The call light was observed clipped to the privacy curtain.</p> <p>On 01/06/25 at 2:10 p.m., LPN #1 stated staff were to clip the call light to the residents' blanket if they were in bed and to keep the call light in reach.</p> <p>On 01/06/25 at 2:11 p.m., LPN #1 was observed to go into Resident #35's room and stated, It's not within [their] reach.</p>

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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45462</p> <p>Based on record review and interview, the facility failed to develop a comprehensive care plan within 14 days of admission for one (#24) of 14 sampled residents whose care plans were reviewed.</p> <p>The DON identified 54 residents resided at the facility.</p> <p>Findings:</p> <p>Resident #24 was admitted to the facility on [DATE] with diagnoses which included acute kidney failure, acute cystitis with hematuria, and indwelling urinary catheter.</p> <p>On 01/06/25 at 2:22 p.m., no comprehensive care plan was present in the EHR nor paper chart for Resident #24.</p> <p>On 01/08/25 at 8:21 a.m., the ADON was asked the process for completing comprehensive care plans for new admissions. They stated care plans for residents receiving skilled services were completed by the corporate nurse within 14 days of admission. After a review of Resident #24's care plan, the ADON acknowledged it had not been completed within 14 days of admission.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>41318</p> <p>Based on observation, record review and interview, the facility failed to ensure heel lift boots were in place as ordered for one (#36) of two sampled residents reviewed for pressure ulcer care.</p> <p>The administrator identified seven residents had orders for heel lift boots.</p> <p>Findings:</p> <p>Resident #36 had diagnoses which included left side hemiplegia.</p> <p>Resident #36's Order Summary Report, dated 05/03/23, documented for heel lift boots to be in place every shift for wound prevention.</p> <p>A Braden Scale for Predicting Pressure Sore Risk assessment, dated 12/18/24, documented Resident #36 was at high risk for developing a pressure ulcer</p> <p>A Quarterly Assessment, dated 12/18/24, documented Resident #36's cognition was severely impaired. It documented the resident had impairment to their upper and lower extremities.</p> <p>On 01/06/25 at 2:31 p.m., Resident #36 was observed laying in their bed. Heel lift boots were not observed on the resident's feet.</p> <p>On 01/07/25 at 7:45 a.m., Resident #36 was observed up in their geri chair in their room. Heel lift boots were not observed on the resident's feet.</p> <p>On 01/07/25 at 7:49 a.m., CNA #1 stated some residents use heel lift boots to prevent pressure ulcers. They stated Resident #36 utilized heel lift boots. CNA #1 observed Resident #36 and stated the resident did not have the boots on. CNA #1 stated Resident #36 was suppose to have the boots on at all times.</p>		