

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER York Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 500 South York Muskogee, OK 74403	

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 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>34270</p> <p>Based on record review and interview, the facility failed to ensure a NOMNC form was provided to a resident within the mandated time frame for one (#10) of three sampled residents reviewed for beneficiary notices.</p> <p>The ADON reported there had been five discharges from Medicare covered part A services in the past six months.</p> <p>Findings:</p> <p>A CMS form 10123 - NOMNC, signed 09/19/24, documented Resident #10's Medicare part A services would end on 09/20/24. The document did not have the resident's signature, but those of two staff members with a written statement that documented the resident's unwillingness to sign.</p> <p>A CMS form 20052 - SNF Beneficiary Notification Review completed by the ADON documented Resident #10 had begun Medicare part A services on 08/28/24 and the last day covered was 09/20/24.</p> <p>On 01/28/25 at 9:10 a.m., the ADON stated residents on CMS part A services were given NOMNC forms at least two days prior to the end of those services. They stated they and another staff member signed the document on 09/19/24 after the resident would not sign the form. They stated because the form was signed on 09/19/24, and the services were to end on 09/20/24, the document was late.</p> <p>On 01/28/25 at 9:17 a.m. the DON stated the facility did not have a policy and procedure regarding beneficiary notices. They stated they instead used CMS guidelines.</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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>34270</p> <p>Based on record review and interview, the facility failed to provide written notices of transfer to residents transferred to acute care hospitals by the facility for three (#17, 27, and #45) of three sampled residents reviewed for discharges and hospitalization s.</p> <p>The ADON stated nine residents had transferred to an acute care hospital in the previous three months.</p> <p>Findings:</p> <p>An undated Transfer and Discharge policy, read in part, Preparation and orientation of the resident is essential to ensure safe and orderly transfer or discharge from the facility. Sufficient preparation means that the facility informs the resident where he/she is going and takes steps under its control to ensure safe transportation. The facility will involve the resident and the resident's family/representative in selecting the new residence. The policy did not include procedures which included notification in writing prior to transfer.</p> <p>1. Resident #17 had diagnoses which included Parkinson's disease and dementia.</p> <p>A nurse's note, dated 12/28/24 at 6:23 p.m., documented Resident #17 had been transferred to an acute care hospital following a fall.</p> <p>A nurse's note, dated 01/05/25 at 7:22 p.m., documented Resident #17 had been transferred to an acute care hospital for altered mental status.</p> <p>2. Resident #27 had diagnoses which included diabetes and heart failure.</p> <p>A nurse's note, dated 12/06/24 at 7:11 a.m., documented Resident #27 had been transferred to an acute care hospital for confusion.</p> <p>3. Resident #45 had diagnoses which included paranoid schizophrenia.</p> <p>A nurse's note, dated 10/05/24 at 9:00 a.m., documented the resident had been transferred to an acute care hospital on for verbal and physical aggression.</p> <p>On 01/28/25 at 10:17 a.m., the DON was asked to provide the written notices of transfer for Resident #17, 27, and #45. They stated they had never heard of a written notice of transfer until that day.</p> <p>On 01/28/25 at 12:22 p.m., the DON stated the facility had not been providing written notices of transfers when residents had been transferred to hospitals. They stated they had searched through the documentation of residents who had been transferred and found no notices of transfers.</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>33097</p> <p>Based on observation and interview, the facility failed to post nurse staffing in a prominent place accessible to residents and visitors.</p> <p>The administrator identified 42 residents who resided in the facility.</p> <p>Findings:</p> <p>On 01/26/25 at 8:54 a.m., a tour of the facility was conducted. No nurse staff posting was observed.</p> <p>On 01/27/25 at 1:40 p.m., the nurse staff posting for the facility was not observed. The DON stated they were not aware the nurse staff posting was not posted or needed to be posted.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>33097</p> <p>Based on observation, record review, and interview, the facility failed to ensure:</p> <p>a. the deep fryer was cleaned after use; and</p> <p>b. refrigerated items were labeled and dated for the residents.</p> <p>The dietary manager identified 40 residents who received meals prepared by the kitchen and two residents who received nutrition via tube feeding.</p> <p>Findings:</p> <p>An undated policy titled Storage of Food in Refrigeration, read in parts, Food being returned to storage after cooking or preparation must be covered .All containers must be labeled with the contents and date food item was placed in storage .Previously cooked foods can be held in refrigeration of 41 degrees F or lower for up to 3 days and then must be discarded.</p> <p>A cleaning schedule documented the deep fryer had not been cleaned the week of 01/20/25 through 01/26/25.</p> <p>On 01/26/25 at 9:12 a.m., a kitchen tour was conducted. The deep fryer had dark grease and food particles around the outside edges of the fryer.</p> <p>On 01/26/25 at 9:17 a.m., dietary cook #1 stated they had not used the deep fryer today. The cook stated the deep fryer did not look like it had been cleaned.</p> <p>On 01/26/25 at 9:21 a.m., a sandwich bag containing six boiled eggs, dated 01/20/25, and an open box of candy (chocolate covered cherries) were observed in the refrigerator not labeled or dated.</p> <p>On 01/26/25 at 4:10 p.m., the DM stated the deep fryer had been used three days ago and the staff did not clean it after use. The DM stated foods stored in the refrigerator should be placed in a container, labeled, and dated. The DM stated foods previously cooked should not be stored for more than 48 hours. The DM stated the boiled eggs had been discarded and the staff educated.</p>		

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34270</p> <p>Based on record review and interview, the facility failed to ensure the facility medical director participated in the quality assessment and performance improvement program.</p> <p>The ADON stated there were 42 residents residing at the facility.</p> <p>Findings:</p> <p>A document titled QAPI Plan for [NAME] Manor Nursing Center, dated 09/30/24, read in part, The goal of a QAPI plan is to provide guidance for performance improvement efforts and assistance with achieving the purpose, guiding principles and scope set in the QAPI program. This plan is a living document that should include input from representatives from all disciplines within the organization and needs to be reviewed and refined at least annually.</p> <p>Thirteen documents titled QAPI Meeting & Agenda, dated on and between 01/25/24 and 12/30/24, documented pre-printed titles of attendees followed by handwritten signatures of those who attended individual QAPI meetings. Each of the forms had the pre-printed words Medical Director followed by a signature line. On each form the signature line for the medical director was blank.</p> <p>On 01/29/25 at 10:09 a.m., the facility administrator stated the quality assurance committee met monthly. They stated they understood the medical director was supposed to participate in at least quarterly meetings. They stated the medical director was available for resident clinical issues throughout the year. They stated the medical director did not participate in the quality assessment and performance improvement program.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>33097</p> <p>Based on observation, record review, and interview, the facility failed to ensure infection control practices were followed for one (#26) of two sampled residents who were reviewed for wound care.</p> <p>The DON identified three residents who were currently receiving wound care treatments.</p> <p>Findings:</p> <p>An undated policy titled Hand Hygiene, read in parts, follow the facility's established hand hygiene procedures to prevent the spread of infection and disease to other staff, residents and visitors .Hands should be washed for at least twenty (20) seconds using soap and water under the following conditions .Before performing invasive procedures .Before handling clean or soiled dressings, gauze pads, etc .After handling used dressings, contaminated equipment, etc .Before putting on gloves .After removing gloves.</p> <p>Resident #26 had diagnoses which included cerebral palsy, spina bifida, and a stage four pressure ulcer to the buttock.</p> <p>A physician order, dated 10/18/24, documented the staff was to cleanse the wound to the right buttock with wound wash, pat dry, apply Medihoney and calcium alginate to the wound bed, and cover with an abdominal pad.</p> <p>A discharge return anticipated, dated 12/06/24, documented the resident was independent for daily decision making and was dependent with most ADL care. The assessment documented the resident had a stage four pressure ulcer that was present upon admission.</p> <p>On 01/27/25 at 9:08 a.m., LPN/charge nurse #1 gathered supplies from the treatment cart. The LPN donned a gown and gloves, entered the resident's room, and placed the supplies on the resident's bedside table. The LPN did not clean the bedside table or provide a barrier for the unclean surface. The LPN did not wash their hands before donning gloves. The LPN cleaned the wound with normal saline and padded the area dry with a piece of gauze. Using the same gloved hands the LPN picked up the Medihoney and calcium alginate dressing and applied it to the wound. The LPN then covered the dressing with an abdominal pad. The LPN removed their gloves and gathered the remaining supplies from the bedside table, exited the room, and placed the supplies on the treatment cart. The LPN did not wash their hands after removing their gloves or clean supplies returned to the treatment cart.</p> <p>On 01/27/25 at 9:22 a.m., the LPN stated they should have washed their hands before donning gloves and after removing their gloves. The LPN stated they should have changed gloves between touching unclean areas and clean areas during care. The LPN stated supplies returned to the treatment cart should be cleaned before returning to the cart.</p>		