STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375151	A. Building B. Wing	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capitol Hill Skilled Nursing and Therapy	2400 Southwest 55th Street Oklahoma City, OK 73119

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 48344 Based on observation, record review, and interview, the facility failed to ensure a call light was within reach of a resident for one (#20) of 24 sampled residents observed for call lights in reach. The administrator identified 65 residents resided in the facility. Findings: Resident #20 had diagnoses which included chronic respiratory failure with hypercapnia. Resident #20's quarterly resident assessment, dated 09/27/24, documented the resident had moderate cognitive impairment. Resident #20's care plan for falls, revised 10/17/24, documented call light in reach and encourage to use. On 11/06/24 at 10:41 a.m., Resident #20 called out to the surveyor and asked the surveyor to hand them their call light. The call light was on the recliner and out of the reach of the resident. Resident #20 was sitting in a wheelchair. The resident was asked how they would call for help with the call light out of their reach. Resident #20 stated, They cant. The resident stated they needed ice water. On 11/06/24 at 10:54 a.m., CNA #4 stated the policy was to ensure the call light was always in reach. They stated Resident #20 could use their call light. On 11/06/24 at 10:55 a.m., CNA #4 made an observation of Resident #20's call light. They stated it was not in reach. CNA #4 pinned the resident's call light to their blanket and proceeded to offer the resident ice water.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 48344 Based on observation, record review, and interview, the facility failed to ensure a resident's ceiling vent was cleaned for one (#55) of three sampled residents reviewed for a clean, comfortable, and homelike environment. The administrator identified 65 residents resided in the facility. Findings: The Housekeeping Policies and Procedures policy, revised 06/29/12, read in part, Weekly Procedures: Begin cleaning resident rooms from the ceiling and work toward the floor. The only part of the room which is allowed to be dry dusted is the ceiling, high vents, and other high dust areas. Resident #55's quarterly resident assessment, dated 10/18/24, documented Resident #55 was cognitively intact. On 11/06/24 at 8:56 a.m., Resident #55's ceiling vent was observed to have moderate dust build up. On 11/08/24 at 12:04 p.m., Resident #55's ceiling vent was observed to have moderate dust build up. Resident #55 stated they had not cleaned the vent. On 11/08/24 at 12:59 p.m., Housekeeper #1 stated they had not paid attention to the ceiling vents in the resident rooms during their cleaning procedures. On 11/08/24 at 1:00 p.m., Housekeeper #1 observed the vent in Resident #55's room. They stated it needed to be cleaned.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 41318 Based on record review and interview, the facility failed to ensure a MDS was coded accurately for one (#42) of 17 sampled residents reviewed for MDS assessments. The administrator identified 65 residents resided in the facility. They identified one resident received dialysis. Findings: Resident #42 had diagnoses which included end stage renal disease. A Care Plan, dated 07/11/24, documented the resident received dialysis at a local facility three times a week. A Quarterly Assessment, dated 10/01/24, did not code Resident #42 received dialysis. On 11/07/24 at 11:01 a.m., MDS Coordinator #1 stated if someone was receiving dialysis then it would be coded on the MDS. They reviewed Resident #42's MDS and stated it was not coded. They stated it was not accurate.

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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. 48344 Based on record review and interview, the facility failed to hold a care plan meeting for one (#35) of one sampled resident reviewed for a care plan meeting. The administrator identified 65 residents resided in the facility. Findings: Resident #35 had diagnoses which included unspecified dementia and need for assistance with personal care. On 11/07/24 at 1:19 p.m., Resident Rep #1 stated a care plan meeting was scheduled for 10/24/24. They stated the facility did not inform them the reason the care plan meeting was not held and if it would be rescheduled. On 11/08/24 at 8:01 a.m., the administrator stated the social worker was responsible for care plan meetings. They stated the current social worker had been in their position for a week. The administrator stated care plan meetings were held quarterly. On 11/08/24 at 8:06 a.m., the administrator stated the last care plan meeting held for Resident #35 was on 07/25/24. They stated another meeting was scheduled for 10/24/24. On 11/08/24 at 8:08 a.m., the administrator stated the care plan meeting was not held because the social worker had quit their job. They stated the family was not notified about the missed meeting or given any information on rescheduling.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35389 Based on observation, record review, and interview, the facility failed to ensure expired medication was removed from circulation in one of one medication storage rooms. The administrator identified 65 residents resided in the facility. Findings: A Medication Storage in the Facility policy, dated ,d+[DATE], read in part, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier . Outdated .medications .are immediately removed from inventory, disposed of according to procedures for medication disposal Resident #12 had diagnoses which included other recurrent depressive disorders. A Physician Order, dated [DATE], documented sertraline (Zoloft an antidepressant medication) 100 mg give one tablet by mouth one time a day related to other recurrent depressive disorders. On [DATE] at 7:07 a.m., the medication storage room was observed with the DON present. The DON stated staff printed off an order, faxed it to the pharmacy, and called the pharmacy to reorder medications. The DON stated the facility ordered different things daily. They stated staff were to follow the first in first out process for rotating stock in the medication room. On [DATE] at 7:09 a.m., a card of pill packed Zoloft 100 mg count of 30 was observed in the medication container labeled for Resident #12. The fill date was [DATE] with an expiration date of [DATE]. On [DATE] at 7:17 a.m., the ADON stated the medication aides were supposed to rotate the medication stock and use what was first received. The ADON stated when a medication was expired, or getting ready to expire, the medication would be pulled and placed with the discontinued medications. The DON and ADON reviewed Resident #12's medication card for Zoloft and stated it was expired.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 48344 Based on record review and interview, the facility failed to ensure a urinalysis specimen was obtained in a timely manner for one (#35) of six sampled residents reviewed for laboratory services. The administrator identified 65 residents resided in the facility. Findings: Resident #35 had diagnoses which included unspecified dementia and UTI. A Physician's Telephone Order, dated 10/15/24, documented CBC, CMP, PCR UA, TSH, and Depakote level for generalized weakness. A Lab Report, dated 10/16/24, documented a urine specimen was collected. On 11/08/24 at 9:27 a.m., LPN #4 stated nurses were responsible for obtaining urine specimens. On 11/08/24 at 9:28 a.m., LPN #4 stated they spoke with the resident's family member on 10/25/24. The resident's family member had inquired about the status of the urinalysis. They stated the urine specimen that was collected was not sent to the lab. LPN #4 stated the urine specimen was still in the ice box. They stated they called the provider to verify it was ok to obtain another urine specimen. LPN #4 stated a new urine specimen was collected on 10/25/24 and lab was called for pick up. On 11/08/24 at 9:38 a.m., LPN #4 reviewed Resident #35's urine lab order. They stated the urine specimen was not obtained in a timely manner. On 11/08/24 at 10:02 a.m., the DON stated staff were to notify lab to pick up urine specimens after collection. On 11/08/24 at 10:04 a.m., the DON stated urine specimens should be obtained as soon as possible.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48344 Based on record review and interview, the facility failed to: a. report an abnormal urinalysis result to the provider in a timely manner for one (#35) of six sampled residents reviewed for laboratory services; and b. develop a lab policy. The administrator identified 65 residents resided in the facility. Findings: Resident #35 had diagnoses which included unspecified dementia and UTI. A Physician's Telephone Order, dated 10/15/24, documented CBC, CMP, PCR UA, TSH, and Depakote level for generalized weakness. A Lab Report, documented a urine specimen was collected on 10/26/24 and reported on 10/29/24. It documented Resident #35 was positive for a UTI. A Physician Order, dated 11/05/24, documented Cipro (an antibiotic) 500 mg give one tablet by mouth two times a day for UTI for seven days. There was no documentation the provider was notified of the abnormal urinalysis result on 10/29/24. On 11/08/24 at 9:32 a.m., LPN #4 reviewed Resident #35's urinalysis result. They stated the results were reported to the facility on [DATE]. On 11/08/24 at 9:35 a.m., LPN #4 stated the provider must have been notified because there was a new order for an antibiotic on 11/05/24. They stated there was no documentation the provider was notified on 10/29/24 about the abnormal urinalysis result. On 11/08/24 at 9:38 a.m., LPN #4 stated the provider was not notified in a timely manner. On 11/08/24 at 10:05 a.m., the DON stated staff were to notify the physician and family as soon as they pulled the results. They stated all nurses had access to the online lab reporting system. On 11/08/24 at 10:19 a.m., Corp Nurse Consult #1 stated the provider was notified about the abnormal urinalysis result on 11/05/24. On 11/08/24 at 10:20 a.m., Corp Nurse Consult #1 stated they did not have a lab policy. They stated the urinalysis result was reported in a timely manner. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/08/24 at 11:02 a.m., Corp Nurse Consult #1 stated they did not have a lab policy on provider notification of abnormal lab results.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 41318 Based on record review and interview, the facility failed to follow up on a physician ordered dental referral for one (#60) of three sampled residents reviewed for dental care. The administrator identified 65 residents resided in the facility. Findings: A Dentures and Related Services policy, dated 06/27/17, documented when the provision of denture services were medically appropriate, the facility must make timely arrangements. Resident #60 had diagnoses which included chronic obstructive pulmonary disease. An Admission Note, dated 06/13/24 at 3:22 p.m., documented Resident #60 wore upper dentures and had their own teeth on the bottom. A physician's order, dated 09/24/24, documented to refer Resident #60 to a dentist for a new upper denture plate. A Quarterly Assessment, dated 09/26/24, documented Resident #60's cognition was intact. It documented the resident had broken or loosely fitting full or partial denture. On 11/06/24 at 9:26 a.m., Resident #60 stated they had lost their dentures about a month ago. They stated they had told their physician and they had wrote an order, but they had not seen a dentist. On 11/12/24 at 9:35 a.m., LPN #1 was asked what the procedure was for when a resident needed to see a dentist. They stated they would obtain an order then give it to the social services worker. LPN #1 stated Resident #60 had an order to see a dentist, but had not seen one. On 11/12/24 at 9:42 a.m., the activities director stated they had helped out with social service duties. They stated if a resident needed to see a physician, and they did not see the vendor who came to the facility, they would have to set up an appointment. They stated Resident #60 had not seen a dentist because they did not know the resident needed to. On 11/12/24 at 9:58 a.m., the activities director stated the previous social service worker had the order, but Never did anything with it.

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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. 48344 Based on observation, record review, and interview, the facility failed to adhere to enhanced barrier precautions for one (#26) of one sampled resident reviewed for enhanced barrier precautions. The administrator identified 65 residents resided in the facility and 19 residents were on enhanced barrier precautions. Findings: The Enhanced Barrier Precautions policy, revised 03/28/24, read in part, Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier precautions include: Device care or use . feeding tube. Resident #26 had diagnoses which included cachexia and severe protein-calorie malnutrition. Resident #26's care plan for EBP, revised 09/24/24, documented the resident was at risk for infection related to peg tube and secondary to in-house MDRO. It documented to maintain enhanced barrier precautions. On 11/06/24 at 2:29 p.m., LPN #2 was observed entering Resident #26's room. There was an EBP sign on the door for bed A. There were gowns hung on a yellow storage container on the bathroom door. On 11/06/24 at 2:30 p.m., LPN #2 with gloves on, removed a split gauze from the resident's peg tube and discarded it. They donned new gloves, cleansed the peg tube site, and applied a new split gauze. Then they applied tape. LPN #2 removed and discarded their gloves and used ABHR. LPN #2 did not wear a gown during the care of the peg tube. On 11/06/24 at 2:33 p.m., LPN #2 stated the EBP sign on Resident #26's door was for handwashing. They stated if the sign were to wear a gown, the PPE would be provided in a plastic bin, and placed outside of the resident's door. On 11/06/24 at 2:35 p.m., LPN #2 stated they did not notice the gowns in the resident's room. On 11/06/24 at 2:36 p.m., LPN #2 stated they did not have to wear a gown during peg tube care. On 11/06/24 at 2:46 p.m., the DON stated enhanced barrier precautions required staff to wear a gown and gloves during peg tube care.

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. 41318 Based on observation, record review, and interview, the facility failed to ensure a resident had a privacy curtain for one (#55) of 24 sampled resident rooms reviewed for privacy. The administrator identified 65 residents resided in the facility. Findings: Resident #55 had diagnoses which included diabetes mellitus type two. A Quarterly Assessment, dated 10/18/24, documented Resident #55's cognition was intact. On 11/06/24 at 8:52 a.m., Resident #55 was observed sitting on their bed in their room. There was not a privacy curtain available to pull across the room to provide complete privacy. Resident #55 stated they would have liked to have one for privacy. On 11/12/24 at 8:26 a.m., LPN #1 stated the curtains were to be closed to provide privacy to the residents. LPN #1 was asked to look at Resident #55's room. They were asked if the resident had curtains to provide privacy. They stated, If [they] want one. Resident #55 stated, Yes, I want one for privacy.